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An Analysis of the Health Visitor -Client Interaction - the Influence of the Health Visiting Process on Client Participation.

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Abstract

The aim of this study was to explore the extent and nature of client participation in health visiting practice within the framework of the Health Visiting Process (HVP). The most appropriate context in which to study this area was seen to be the health visitor/client interaction since this is the point at which the client can potentially have most involvement.

Sixteen health visitors from two health authorities took part in the study. Area A had implemented the HVP three years previously whilst health visitors in area B used a traditional approach to practice. These two groups of health visitors were observed visiting families with children under one year at home, excluding primary visits, and the interaction between the health visitor and client was audio-recorded. A total of 62 interactions were analysed. The health visitors and clients were also interviewed separately to establish their individual perceptions of the visit. In addition, data were collected from the health visitors about their views and attitudes towards client participation and the HVP. Qualitative methods were used in the analysis of the interaction data whilst a quantitative approach was taken with the interview data, thus providing a degree of triangulation.

Findings from the interaction data suggest that health visitors in this study did not generally facilitate client participation in identifying their own needs or in planning and decision making to meet perceived health needs. There appears to be little difference in approach between health visitors from the two areas. These findings are validated by the interview data which show that health visitors and clients had differing perceptions of a home visit.in terms of the perceived objectives of the visits, the perceived health needs, the perceived plan of action and perceived follow-up. Despite these observations, health visitors in both groups tended to be positive about the concept of client participation.

In conclusion, the health visitors in this study were unable to demonstrate in practice their apparent commitment to client participation. The HVP did not appear to make any appreciable difference to health visiting practice. This has implications for the education of health visitors and for practice. An explanation for the findings appears to lie in the health visitors' lack of a theoretical framework for practice and some further study into the development of a theory of health visiting is recommended.

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Introduction

The role of the health visitor which focusses on the prevention of ill health and the promotion of positive health is unique. There is no other group of nurses who deals exclusively with well members of the community. It is difficult to identify a similar type of practitioner in countries other than the U.K. Whilst many endorse the health visitor's role in child health (While 1985, Bedford 1988) and in health promotion of the wider community (Ashton, 1990, Weir 1991), it is argued by some that the future of health visiting hangs in the balance. Goodwin (1988) and Fatchett (1990) for instance, both identify changes in the direction of health visiting if the profession is to survive into the 21st century. The changes suggested are that the health visitor should have a broader based community role and that the concept of client participation should be central to practice. These changes have largely been identified through the necessity to respond to consumer demand, to demographic change and to health policy. However, whilst there appears to be an assumption that health visitors are ready to take on this role (Goodwin 1988, HVA 1988) research to date suggests that they are ill-prepared and that barriers between client and professional are very much in evidence (Sefi 1985, McIntosh 1986, Foster and Mayall 1990).

There has been increasing interest in client participation since the World Health Organisation proposed that:

> "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (WHO, 1978)

The issue has been particularly addressed by the medical profession from the point of view of patient compliance (Roter, 1977) but the concept has been increasingly widened to embrace aspects of the professional-client relationship such as decision making (Tucket et al, 1985). It is only in more recent years that nursing has begun to address the issue of client participation (Kim, 1985, Brooking, 1986) and there is no known existing research in health visiting which explicitly explores this concept. However, the issue of client participation is perceived to be of particular relevance to a profession where

health promotion is central to the work. Prevention of ill-health and promotion of positive health may often be perceived by clients to be unmeasurable and unobtainable. Changes in behaviour or lifestyle which are imposed by the health visitor are less likely to be achieved than those where the client identifies her own health needs and plans health promotion strategies *with* the health visitor to meet those needs. Participation is a concept central to Health Visiting Process (Maukch and David, 1972) and as such merits investigation.

The Health Visiting Process (HVP) has been promoted as a framework for health visiting practice (Clark, 1985). The approach is based on the Nursing Process (Kratz, 19 79) and as such can be seen to involve assessment of need, planning of care, implementation of care and evaluation of care. Such a framework, in theory, provides a more individualised approach to care and, according to Maukch and David (1982), encourages client participation. It is clearly important to explore the influence that such a framework may have on client participation.

The focus of this study is the health visitor-client interaction as, in current health visiting practice, this is perceived to be the point at which clients potentially have the greatest opportunity to participate. Whilst several previous studies have described the health visitor-client interaction (Clark 1985, Sefi 1985, Montgomery-Robinson 1987) none have looked at encounters between clients and health visitors after the primary visit, and none have focussed on the concept of client participation nor investigated the potential of HVP for promoting participation. The purpose of the current study is therefore to combine these elements and to explore client participation in the health visitor-client interaction and examine the influence of the HVP on such interactions. An additional dimension to this study is the exploration of health visitors and clients perceptions the home visits and the encounters and the degree to which these perceptions were congruent.

Chapter one of this study presents an historical perspective on the role of the health visitor and changes and developments within the health visiting profession from its beginnings in the 19th century public health forum to the present day. It is argued from the perspective presented by Dingwall (1977) that health visiting started as a collectivist occupation which became progressively individualist in its approach in response to changes in social policy and ideology. In the present climate, where health visitors are being encouraged to move back towards a public health perspective, a collectivist approach is again seen to be relevant. However, if future health visitors are to be proactive in public health issues then client participation is an important element of this approach. Currently, practice continues from an individualist perspective, but to what extent are health visitors encouraging client participation? The possible effects of recent developments relevant to health visiting such as the Health Visiting Process and Project 2000 (UKCC, 1986) are explored.

In chapter two the existing research into the nature of health visiting practice is documented. A detailed analysis of the literature identified a few studies exist which explore the process of health visiting in depth. Most of these are based on small samples (Sefi 1985, Montgomery-Robinson 1987) and only address the primary visit by the health visitor. Research into health visiting practice beyond the primary visit was therefore seen to be important, as relationships change and develop.

In chapter three the research which has attempted to evaluate the effectiveness of health visiting is explored. Whilst some of the problems of evaluating a preventative service are acknowledged, the chapter addresses evaluation from the perspectives of health outcomes, approaches such as client behaviour change and consumer satisfaction.

The concept of client participation is examined in chapter four. Much of the available research concerns the doctor-patient relationship and some of this research does have relevance to health visiting, particularly in relation to primary care encounters. Concepts such as compliance were not seen to be appropriate to health visiting, whilst issues such as participative decision making, mutual assessment of need and mutual goal setting were seen to be very relevant. However, overall, there is very little available research into these aspects of nursing or health visiting. Thus, it emerged that a perceived gap exists in the health visiting knowledge base which addresses the extent to which clients participate in health visiting activities. It was therefore seen to be important to carry out an in-depth study of the nature of the health visitor-client imteraction, focussing on client participation.

In chapter five the methods used in this study are discussed. A qualitative approach was taken to analysing 62 tape recorded conversations between health visitors and clients, drawing on ethnomethodolgy (Garfinkel, 1967) and particularly on conversation analysis (Heritage, 1984). A more quantitative approach was taken to interviewing clients and health visitors about their perceptions of a visit. A comparative design to the study was employed in order to explore the potential influence of the Health Visiting Process on client participation.

In chapters six and seven the findings from the study are presented and strands of quantitative and qualitative analysis are drawn together.

Possible explanations for the findings are sought in chapter eight. A number of perspectives are explored including the concept of professional control, lack of communication skills and lack of a theoretical framework for practice. The implications for health visiting education and practice are discussed.

Finally, it is recommended that future research should be directed at testing and validating existing theory in the context of health visiting and client participation, that theory should be inductively generated and that the value of client participation in health visiting must be evaluated. It is imperative that such research is on-going in order that health visitors will continue to play an important and effective role in health promotion in the future.

Chapter One

Changing Perspectives in Health Visiting - an historical overview.

Introduction

This chapter documents the historical development of health visiting and charts the shifts in emphases which have occurred within this professional group. Originally, health visitors saw themselves as having a community role, working collectively for public health but then moved towards a more individualist approach during the post-war era (Dingwall, 1977). More recently, a community approach is again being advocated with emphasis on client participation and community involvement (Orr 1985, Mayall and Foster 1988, Health Visitor's Association 1988). The history of health visiting has been comprehensively reviewed by previous authors (Clark 1973, Dingwall 1977, Robinson 1982 and While 1985). The account which follows represents a selective review of the literature illuminating the historical development of health visiting and factors which have influenced these shifts in emphasis between individual and community and the growing interest in client participation .

The Rise of Health Visiting

It is a widely held view that the first health visitors originated from a rising interest in public health during the middle of the 19th century following two epidemic outbreaks of cholera (Dingwall 1977, Robinson 1982). Chadwick's report of 1842 on the Sanitary Conditions of the Labouring Classes prompted the realisation that grossly inadequate water supplies, drainage systems and refuse disposal were largely responsible for the outbreak of the disease and that prevention through legislation was an important step towards combating ill health. Thus, the first legislation in public health, the Public Health Act of 1848 was invoked.

As Dingwall (1977) has pointed out, the main response to the Act was largely on a private, collectivist basis. The State did not accept responsibility for educating society in health issues as there were a large number of voluntary and charitable organisations

who saw it as their responsibility to work within the community. The role of these organisations was perceived to be one of enabling the community as a whole to overcome the devastating effects on health of poverty, poor housing and intolerable work conditions. Within this context the first health visitors are reported to have originated from Salford, Manchester. They worked on a voluntary basis and were known as the Salford Ladies Sanitary Reform Association. The cholera epidemics of 1832 and 1848 had been evidence enough that the health of the middle classes was inseparable from the health of the working classes and the Ladies therefore saw the maintenance of health as a community problem requiring action on a community basis. As Armstrong (1988) has discussed, public health was perceived at this time as the interaction between man and environment rather than being determined by the individual's behaviour.

Therefore the model of a family visitor emerged based on the service provided by the Ladies, primarily through home visiting on a universal basis without test of need. Although some work was of a practical nature with the sick, it is clear that there was an expectation that the visitor would provide a role model within the community of cleanliness and hygiene as well as educating and persuading the people she visited in these ways:

> "She had not only given instruction in common sanitary rules but she would herself wash and make comfortable a sick person whom she might find neglected or dirty, thus encouraging those who were around to follow her example by showing people how to do what was needful in the best way."
> (Annual report of Manchester and Salford Sanitary Reform Association 1868, cited by Dingwall 1977).

In 1867 the first paid worker was taken on by the Association. Many of the paid workers came from the communities within which they worked and received wages on a similar scale to those they were visiting which enhanced the ideology of a community worker. Together with the fact that all homes were visited regardless of need this helped to maintain an astigmatised service.

The paid workers were given some basic training in hygiene and were expected to teach the families they visited:

> "..the women in the district are shown the evils of dirt and the dangers of living in unhealthy dwellings - they are taught to prevent the spread of disease and the laws generally which will enable them and their families to lead moral and healthy lives"
> (Interdepartmental Committee 1904, cited by Dingwall 1977)

The Influence of Florence Nightingale

The views of Florence Nightingale extended beyond the traditional nursing role of care of the sick and into the role of the nurse in prevention of illness. She wrote, in 1891, to Sir Frederick Verney that she:

> "looked forward to the day when there would be no nurses of the sick, only nurses of the well."
> (Cited by Clark, 1973).

Nightingale saw the role of the health visitor as quite distinct from nurses and it was under her influence that the first health visitors to be wholly employed by a County Council were engaged in 1892 in Buckinghamshire. She described the work of these health "missioners" in a paper entitled "Sick Nursing and Health Nursing" given at the Chicago Exhibition of 1893:

> "The scheme (for health at home nursing) contemplates the training of ladies, so called health missioners, so as to qualify them to give instruction to village mothers in:
>
> 1. Sanitary conditions of the person, clothes and bedding and house.
> 2. The management of the health of adults, women before and after confinements, infants and children."

Nightingales' environmental model of nursing can be traced back to the health missioners of Buckinghamshire, but as Dingwall (1977) points out, the scheme disappeared without trace and had no real effect on national policy. However, the origins of modern health visiting as a universal agency which aims to enable people to make healthy choices can be traced back to this period.

The Growing Emphasis on Child Health

The question of infant mortality became one of national concern around the turn of the century. Interest in child welfare by the Medical Officers of Health and the realization that a group of personnel (i.e. health visitors) already visited mothers and infants led to a change in focus in health visiting activity away from the whole community towards infants. From 1905 a system of routine visiting to all newborn infants was established in Huddersfield and by 1915 the Notification of Births Act made this possible all over the country. Emphasis was laid on the care and health of the baby but visits were not enforceable. Clark (1973), in an attempt to refute the stereotyped image of the health visitor has suggested that during this period health visiting was not delivered in a didactic or authoritarian manner and that the function of the health visitor were those "of a friend of the household" (Bostock-Hill, 1903). However, given the moralist basis of much of the early visitors motivation to take up this work, it seems unlikely that they entered households free from middle-class, Christian values and attitudes. Indeed, there is evidence to suggest that the visitors were not always welcome. Although there is no direct evidence from consumers of the period, Robinson (1982) cites some indirect evidence that there were cultural discrepencies between the providers and recipients of the service. For example, in her evidence to the Interdepartmental Committee of 1904, Miss Martindale (a sanitary inspector) noted that there was "appalling ignorance and objection to being taught". Similarly, the historian Thomson (1965) has suggested that sanitary reformers were seen as 'infidels' since the death of a child was perceived as the will of God.

Many explanations were offered for the poor health of the working classes leading to high infant mortality rates and these included rural education, working mothers and women who worked before marriage. However, the Interdepartmental Committee in Physical Deterioration of 1903-4 was disinclined to accept these individualistic views and was more in favour of believing that the causes lay in overcrowding, pollution, poor living and working conditions and a lack of health education. It was clear that only

collectivist action by the State would help to overcome these inequalities. It is interesting to note that whilst infant mortality rates have declined in the decades following the introduction of immunisation against diseases such as diptheria (DHSS 1984), the emphasis within health visiting has remained very clearly on child health. It is only recently that the arguments surrounding inequalities in health and the potential of community involvement and participation on promoting health have emerged (Black Report 1980, Whitehead1987, Alwyn-Smith and Jacobson 1988, Public Health Alliance 1988). Dingwall (1977) suggests that the public health campaign in the 19th century was largely continued by local authorities rather than central government and that it was popularised by discussion of infant mortality. Similarly, today it is argued that it is the local authorities who are taking the initiative with community-based projects (Public Health Alliance, 1988).

In 19th century Britain, this interest in infant mortality was followed by a marked increase in voluntary health visitors and an increasing interest in qualification for the work. In 1908 the Royal Sanitary Institute began to set examinations and award certificates in health visiting. Following the Maternity and Child Welfare Act of 1918 local authorities were required to set up maternity and child welfare committees taking responsibility for attending to the health of expectant and nursing mothers and children under five. This led to even more stringent educational requirements from prospective health visitors. A nursing background was not a pre-requisite for health visitor training until 1962, but Medical Officers of Health preferred their candidates to be nurses and a midwifery qualification was requiried by some authorities. By 1925 the midwifery qualification was statutory and by 1928 unqualified workers were prohibiited. The introduction of the midwifery qualification was significant in two major ways. It meant that for 40 years men were barred from becoming health visitors and also that health visiting itself became much more orientated to infant welfare whilst the social and environmental aspects of health visiting declined. MacQueen (1962) feared that this change in orientation would mean that the health visitor would become, in the minds of the public, simply a baby nurse, no longer a general teacher of

health. As Clark (1973) points out, this indeed was the case with the effect that the 1930's image of the health visitor as a child health expert has persisted into the 1980's despite the efforts of the Jameson Report (Ministry of Health,1956) to promote the health visitor as "an all purpose family visitor".

Changes since the introduction of the National Health Service

The setting up of the National Health Service in1948 brought further changes and challenges into health visiting. Other changes occuring simultaneously also affected the health visitor's work. The Children's Act of 1948 removed the responsibility from health visitors of the supervision of foster children and the assessment of prospective adoptive parents, the National Assistance Act 1948 gave responsibility for the care of the handicapped and elderly to the Welfare Department. As a result, there was much inter-professional rivalry and confusion of roles and subseqent decline in the number of health visitors. A working party was set up to advise on the proper field of work, recruitment and training of health visitors which resulted in the report 'An Inquiry into Health Visiting,' generally known as the Jameson Report. (Ministry of Health 1956). This report concluded that:

> "...In the ordinary course of her work she (the health visitor) could be in a real sense a general purpose family visitor."

However, this function was further confused by the reports of Younghusband (Ministry of Health,1959) and Seebohm Committees (1968) on social work. The Younghusband Committee reported that no single type of worker could provide a comprehensive health and social service, whilst Townsend (1970) commented that the Seebohm Committe had lamentably failed to recognise the importance of a routine preventative service. Although the Jameson Report (MOH,1956) had defined the function of health visiting as "health education and social advice", these two reports on social work made it no clearer where health visiting sat in relation to social work. This added to the confusion over the emphasis on health visiting work by negating the health visitors concern with the social aspects of health.

In 1962, a significant organisational change took place when the Council for Education and Training of Health Visitors (CETHV) took over the responsibility of training from the Royal Society of Health and the Royal Sanitary Association of Scotland. A new syllabus was introduced and requirements for entry into health visiting changed. For the first time it became mandatory to be registered as a nurse. At this time the CETHV stated that:

> "Health visitors are practitoners in their own right detecting cases of need on personal initiative as well as acting on referrals."

However, this professional autonomy has been gradually undermined by changes within the Health Service in general and within nursing management in particular. For example, the reports of the Mayston Committee (1969) the Salmon Committee (1973), the Briggs Report (1972), the Royal Commission on the Health Service (1979), the re-organisation of the Health Service in 1982 and the Griffiths Report of 1984 have each brought changes in the structure and management of nursing which have meant that health visitors may no longer be accountable to managers with experience in community health. In consequence, their ability to function autonomously has been seriously compromised and this has undermined their potential to work with the whole family and the community. Such problems have been recognised by the Royal College of Nursing (RCN) (1983). In addition, social policy changes brought about by the Court Report into child health (1976) and the Warnock Committee (1978) on services for handicapped children have both served to ensure that the main function of health visitors rests with children.

Within this framework of political and social change various bodies have attempted to address what the role and function of the health visitor should be. In 1977 the CETHV reported its "Investigation into the Principles and Practice of Health Visiting". The document comments on two main domains - the function of the health visitor and the principles which guide the health visitor's practice.

The CETHV (1977) defined the role and function of the health visitor as follows:

> The professional practice of health visiting consists of planned activities aimed at promotion of health and prevention of ill-health. It thereby contributes substantially to individual and social well-being by focussing attention at various times on either an individual, a social group or a community. It has three unique functions:
>
> i) Identifying and fulfilling self-declared and recognised as well as unacknowledged and unrecognised health needs of individuals and social groups.
> ii) Providing a generalist health agent service in an era of increasing specialisation in the health care available to individuals and communities.
> iii) Monitoring simultaneously the health needs and demands of individuals and communities, contributing to the fulfilment of these needs and facilitating appropriate care and service by other professional health care groups". (CETHV 1977)

These functions can be fulfilled, according the CETHV, by following four guiding principles for practice which are:

> "1. The search for health needs
> 2. The stimulation of the awareness of health needs
> 3. The influence on policies affecting health
> 4. The facilitation of health enhancing activities" (CETHV 1977)

Orr's (1985) detailed analysis of these concepts demonstrates how, in theory, health visiting could return to its collectivist values of community participation within the existing professional framework.

In 1983 the Royal College of Nursing (RCN) Society of Primary Health Care Nursing produced a document entitled "Thinking about Health Visiting" in which the role of the health visitor is explored and particularly the position of health visiting within nursing. The RCN claim that health visiting is nursing and, whilst recognising some of the problems associated with basic nurse training as a preparation for health visiting, suggest that the skills required for health visiting are the skills necessary for all aspects of nursing care. The Health Visitors Association (HVA, 1980) on the other hand have argued against the compromising position that being part of the nursing structure has placed health visiting in. The emergence of the United Kingdom Central Council(UKCC) for Nursing, Midwifery and Health Visiting has meant that the training body for health visitng (CETHV) has now been replaced by an umbrella education and training system for nursing, controlled by the National Boards.

In its report the RCN (1983) recognised "the shortcomings of the present system of basic nursing training for the educational preparation of health visitors" (p.28). These shortcomings are to some extent being addressed by two further reports - 'Project 2000" (UKCC 1986) and the Report of the Communtiy Nursing Review (The Cumberledge Report 1986).

The terms of reference of the Cumberledge Committee (1986) were both to report on how nursing services in the community could be most effective and also how services could be improved for client groups. In so doing, this is one of the few reports which places direct emphasis on client need. In its recommendations the Report builds on the concept of teams working together in primary health care but re-introduces the idea of health visitors (and other community nurses) working within a "neighbourhood" which would be geographically determined whilst remaining "attached" to a particular General Practice. The underlying argument for such a structure is that a health visitor is better able to assess and respond to the needs of a particular community or neighbourhood with which she is thoroughly familar and that she in turn will become a familiar figure to the clients who will feel more able to approach the health visitor. In contrast to "attachment" to General Practice in which health visitors are responsible for the clients on the GP list which may be spread over a wide geographical area, the neighbourhood scheme provides an opportunity for health visitors to practice wthin the principles set out by the CETHV in 1977. The "search for health needs" for example becomes a more tangible concept when put into the context of a small neighbourhood where health visitors and other primary health care workers are communicating with each other and with members of that community. It provides quite clearly an opportunity for health visiting to move away from its individualistic stance towards a more collective and participative approach.

Recent research by Foster and Mayall (1988) has highlighted the interventionist nature of health visitors work which is not always viewed by parents as being very helpful. A service which is responsive to need is seen by the authors as more appropriate. A study carried out in Paddington (Drennan 1985) has shown how effective health visiting can be in terms of enhancing community awareness about health issues when a community approach is taken to the work, although a long term evaluation of this study is not reported. A responsive service which addresses both individual and community need could be envisaged within the Cumberledge framework for neighbourhood nursing and some Health Authorities are developing the idea.

Health Visitors must also respond to Government strategies for Community Care. The National Health Service and Community Care Bill (DOH, 1990) proposes that people currently in long term institutions can be more effectively cared for in the community. Working closely within a neighbourhood would enable health visitors and other nurses to assess the needs of the very vulnerable groups which will be increasingly a part of the community. Whilst the government perceives a shift in emphasis from health to social services, there will inevitably remain a need for the health services and perhaps the neighbourhood approach would enhance teamwork between health and social services. It would potentially provide a framework for a family orientated approach as informal carers are perceived by the Government to be an integral part of the community care network. The nature of these groups (e.g. people who are elderly or mentally ill) will necessitate a move away from child-oriented practice for health visitors.

Implications of Project 2000

Project 2000 (UKCC 1986) outlines changes in nurse education which will become operational in the 1990's. The main change affecting health visiting is that a common core curriculum for all nurses is proposed which will be orientated towards health and the community rather than the traditional biomedical model of nursing. Students will take up health visiting as an option on completion of the selected branch programme (adult care,paediatrics, mental health, mental handicap) which will in itself prepare the nurse for work in the community as well as the hospital setting. This will hopefully alleviate some of the problems recognised by the RCN (1983) in the current preparation that nurses have for taking up health visiting. Health visitors of the future will have the chance to embrace the ideology of community health from a theoretical perspective which will have been the foundation of all their learning and knowledge, rather than an "added extra" to the current basic nurse training. It remains to be seen whether this new model for nurse education will be effective in producing "health orientated" nurses.

The indications are that future directions for health visiting must lie in a community model of practice. Concepts central to such a model include health and participation. The concept of participation is crucial to a service which is both responsive to need and faciliative in its approach. In 1985 the Health Visitors Association defined health visiting:

> "The health visitor, by promoting health and health policies, empowers people to take responsibility for health as individuals, families and communities, and thereby helps to prevent and minimise the effects of disease, dysfunction and disability" (Health Visitors Association 1985).

This definition attempts to reflect a philosophy of health visiting which states that health visitors are pro-active - searching out health needs, facilitating and initiating changes and working in partnership with clients and colleagues to promote health. The definition works on the assumption that this is the current state of health visiting practice . However, research into the consumer's view of health visiting (e.g. McIntosh 1986, Foster and Mayall 1988) suggests that this definition is rather ideological. For

example, MacIntosh (1986) has suggested that consumers do not find the present authoritarian style of health visiting helpful. However, the opportunities for health visiting practice to develop in the direction of the HVA definition do exist as Drennan (1985) demonstrated in her study which showed that health visitors can facilitate community developments. The Health Visitors Association have endorsed the concept of "participation" in meeting consumer needs in their document "Bridging the Gap" (1988). It is recognised that to practice within the philosophical framework of the Health Visiting Association definition of health visiting (1985) the client must participate in the recognition and assessment of need in order for the response to need to be both facilitative and effective. The report explores the concept of participation from a consumerist perspective and concludes that further research and training in health visiting are necessary in order to prepare health visitors for a participative role.

Their main recommendations for research are as follows: investigating ways of meeting the need of clients, investigating ways of enhancing client participation, finding out <u>how</u> clients wish to be involved and exploring the one-to-one relationship between health visitiors and client - how to break down barriers. The current study is particularly concerned with the fourth research suggestion as it is clearly important to understand more about health visitor-client relationships before recommendations for client particpation can be implemented.

Drennan (1985) has suggested that -

> "people should be able to gain access to knowledge and information in an appropriate way and gain confidence in using it - that will only happen when health professionals like health visitors are openly able to share their knowledge and expertise and engage in an equitable dialogue with the communities they work in " (Drennan 1985, p. 7).

The approach has been most recently endorsed by the RCN (1988) in its Commission on the NHS chaired by Rabbi Julia Neuberger. As one of its main recommendations the report suggests that:

> "All parts of the health service...must alter this procedure and attitudes to facilitate the development of consumer opportunity and changes" (reported in Lampada, September,1988).

It seems possible that current directions and debate about health visiting will give rise to a new direction for health visiting. However, it is clear that research into the existing skills and perspectives of practice are a necessary pre-requisite for change.

The Health Visiting Process

An important recent development in health visiting practice has been the emergence of the Health Visiting Process (HVP). This development can be traced back in the literature to 1982 (Rogers 1982) which is comparatively recent when compared with the fact that the concept of the Nursing Process itself appeared in the 1960's. It is important to gain a perspective of the history of the Nursing Process before addressing the development of the Health Visiting Process. Previous authors have given a full historical account of the development of the Nursing Process in the U.K. (De La Cuesta 1983, Casteldine 1981) and the current review will therefore be selective, focusing on land marks which are relevant to this study and the growth of the HVP.

Henderson (1987), in an attempt to trace the origins of the term "Nursing Process", suggests that it arose primarily from the work of the U.S. nurse, Orlando (1961). Orlando was particularly interested in the psychosocial aspects of nursing which she was studying in the late fifties. In 1961 she wrote :

> "The purpose of nursing is to supply the help a patient requires in order for his needs to be met. The nurse achieves her purpose by initiating a *process* which ascertains the patient's immediate need and helps to meet the need directly or indirectly" (Orlando,1961:8).

Orlando believed in and promoted the dynamic relationship between nurse and patient and her writings on the Nursing Process are based on this communication, or as she states, on the sharing of "perceptions, thoughts and feelings" (Orlando, 1961). Thus, in Orlando's time the concept of participation was implicit in the Process of Nursing. She believed that one important aspect of the Process of Nursing was the nurses' evaluation of not only her actions to help the patient but also her *reactions*, suggesting that nurses should develop reflective skills and self-awareness in the communication process with the patient. This early work has important implications for the way in which the Nursing Process has been developed and implemented both in the U.S. and the U.K. in relation to client participation. Over time, the focus of the Nursing Process seems to have changed, moving away from the nurse-patient relationship and the concept of participation towards a more systematic and mechanistic method for managing and accounting for care. Indeed, Henderson (1987) suggests that this move became evident in the U.S. by 1980 when a group from Yale University described the Nursing Process as :

> "determining the client's problems, making plans to solve them, initiating the plans or assigning others to implement it, and evaluating the extent to which the plan succeeds' (George, 1980).

As Henderson suggests, this definition appears to be more closely aligned to a scientific, biomedical problem solving approach to nursing than to the psychosocial approach advocated by Orlando (1961). This apparent need to put nursing into a more scientific framework coincided with a period when nursing was trying to "prove" itself as a research based profession.

Mauksch and David (1972), in fact, prescribed the Nursing Process as the intervention for an ailing profession that had not produced "visible autonomously effective practice".

Whilst Mauksch and David (1972) suggest that one of the central facets of the Nursing Process is patient participation, it may be seen that the implementation of the Nursing Process as a way of addressing issues such as professionalism has led to the concept of client participation being under-valued.

In her comprehensive review of Nursing Process, Walton (1986) has outlined the main areas of professional concern which it was hoped the Nursing Process would address. These concerns were picked up by the Briggs Committee in its report on Nursing in 1972. Briefly, these were : to identify and clarify the role of the nurse, to achieve professional status for nursing and its acceptance as an academic discipline, to counterset falling standards of care and attendant decline in job satisfaction, to narrow the gap between theory and reality in education and to re-establish the centrality of the clinical nursing role.

As well as attempting to achieve these objectives, the Nursing Process was seen as a vehicle for enabling the nurse to give high quality, individualised care. Whilst the move away from task orientated care to individualised care has been of paramount interest to nursing, the route to achieving this change i.e. the nurse-patient relationship, seems to have been missed in the rush for professionalization and recognition as an academic discipline. These issues will now be addressed.

Professionalization

According to Friedson (1978):

> "It is useful to think of a profession as an occupation which has assumed a dominant position in a division of labour, so that it gains control over the determination of the substance of its own work. Unlike most occupations it is autonomous or self-directing".

De la Cuesta (1983) has maintained that introduction of the Nursing Process to the U.K., whilst sharing antecedent ideas with the U.S., was a modified version adapted to the British context. She suggests that, in fact, British nurses placed rather less emphasis on professional issues such as accountability, decision making and problem solving. Moreover it appears that whilst issues such as accountability were not apparent in the literature which specifically addressed the Nursing Process, they were certainly professional concerns which were debated in nursing generally throughout the late seventies and onwards (Chapman 1980). The Royal College of Nursing (1989) also identified the issues of professionalization and accountability as central in their discussion document "Towards Standards".

The Nursing Process was seen as a method of validating "basic" nursing by "re-defining it as a problem-solving, decision making activity" (Walton, 1986). This decision making element was seen by Hockey (1978) as "the most crucial of nursing activities". Decision making as a crucial aspect of professional ideology was taken up by Rhodes (1984) in his exploration of nurses' perceived professional role in relation to clinical decision making. A basic tenet of Rhodes' argument that nurses have largely accepted a professional ideology as opposed to a paramedical or bureaucratic ideology, is that the Nursing Process model is to all intents and purposes a decision making model. Rhodes formulates this tenet from discussions with nurse managers and the literature which appears to have reinforced the philosophy of a systematic, problem solving approach to care. Rhodes does not challenge this assumption despite previous discussion with reference to Orlando (1961) for instance. There is no apparent reference by Rhodes, for example, to the idea of the process of nursing being a socio-dynamic process involving reflective and communication skills as well as decision making skills. This perhaps reflects the views of his selected sample i.e. nurse managers. Field (1987) has also suggested that the Nursing Process is a process of logical-deductive problem solving. Whilst acknowledging Henderson's (1982) argument that this analysis ignores the

intuitive aspects of nursing, Field nevertheless holds to a view of the "expert" nurse as an autonomous decision maker. Such views which appear to equate Nursing Process with professionalism and nursing expertise fail to take into account the potential actions of patients and clients. Donnelly (1987) has argued, however, that the Nursing Process does not in itself lead to independent decision making. Donnelly sees the Nursing Process approach mainly as a catalyst in the search for professional autonomy and that elements basic to the realization of nurses' potential as autonomous decison makers are self-esteem, assertiveness and a continuously expanding knowledge base. By the late 1980's, a re-emergence in nursing can be observed of the philosophy of nursing process as seen by its original proponents such as Orlando. These focus on the centrality of the nurse-patient relationship. Donnelly (1987), for example, has argued that the Nursing Process should be embedded in a philosophy of nursing care that "acknowledges the client's active status and right to have a voice in decision making".

As Henderson (1987) has suggested, the Nursing Process as currently described does not adequately address "the patient's role, the importance of health education in recognizing problems, nor a unified approach on the part of the public and health care providers in identifying and dealing with health problems". It appears that whilst professional autonomy, particularly in relation to decision making, has taken precedence in some interpretations of the Nursing Process, other authors have challenged the reductionist approach that this imposes. Professionalization issues appear to preclude the client as a participative decision maker since emphasis is placed on the nurse as the expert decision maker. This raises questions about the compatibility of the concept of client participation with the Nursing Process.

The discussion on professionalization has also percolated into the health visiting literature. In 1977 the CETHV recognised the need for a body of theoretical knowledge to underpin the four principles of health visiting. It is, perhaps, this aspect of professionalism, that is theoretical knowledge, which has been of more interest to

health visitors than the concept of becoming an autonomous decision maker. Certainly, Rhodes (1985) found that the health visitors in his study were unable to respond to many aspects of decision making presented to them. This was partly the result of an ill-designed instrument in that many of the scenarios presented were not relevant to health visitors, but it could equally be indicative of health visitors' perceptions of themselves as decision makers.

Walton (1986) has suggested in her relatively brief analysis of Nursing Process in the community, that autonomous function among health visitors was already well established and that they could "claim with justification that they were doing it (Nursing Process) already (Walton 1986 :24). Walton supplies very little evidence on which this claim could be based but there does seem to have been an assumption made by many health visitors that they practice autonomously and that they could therefore dismiss the Nursing Process as inappropriate to health visiting. The evidence for this seems to be overwhelmingly anecdotal. The search for health visiting knowledge has been more widely supported. Since 1980, Clark has been at the forefront of a "campaign" to establish a theoretical knowledge base for health visiting practice. Clark, like many others in nursing, generally sees the development of a theoretical framework for practice as prerequisite to the development of a body of health visiting knowledge, since theoretical constructs can be tested and validated through research. Through a series of papers (Clark 1980a, 1980b, 1980c, 1982, 1985) Clark has described and argued the case for a systems theory approach to health visiting using a Nursing Process framework to operationalise it. Clark's conceptual model stems from Von Bertalafny's (1968) General Systems' Theory and Neuman and Youngs (1972) model of nursing. It could be argued that Clark has paved the way forward for debate among health visitors on both the applicability of this theorical perspective to health visiting and its relevance to practice. However, there has been very little response to Clark's challenge to use the theoretical framework as a basis for professional research and debate. Thus, where the

health visiting process has been implemented it has frequently *not* been on the basis of a sound professional knowledge base derived from research (e.g. McKay et al 1988).

This begs the question of whether health visitors generally recognise the need for a dynamic approach to theory-based practice or whether they believe the knowledge base exists in a static format. Robinson (1985) has explored the nature of knowledge in health visiting. She defines two knowledge states -scientific knowledge and occupational knowledge. Scientific knowledge is seen as the "objective" knowledge that is acquired by academics for its own sake whilst, according to Robinson, occupational knowledge is not scientific because:

> "it contains notions of occupational priority and goals which are not compatible with any scientific notion of detachment or with the scientific goal of complete understanding" (Robinson 1985:160).

However, as Robinson argues, the scientific approach to knowledge has been seen by nursing to be the only route to truth whereas other routes may be equally rational and valid. Nursing or health visiting theories are, in Robinson's terms, occupational theories. She argues that they are not scientific since they arise from the needs of practice and are validated (sometimes) in practice and they may incorporate other scientific theories. For example, Neuman and Young's (1972) theory of nursing encompasses System Theory. Health visitors use such theories to describe and organise their work and the concepts become intrinsic to the practice of health visiting. Thus, Robinson appears to be suggesting that, unlike scientific knowledge, health visiting knowledge has little meaning outside the practice of health visiting. Whilst Robinson is at pains to point out that occupational knowledge is as valid as scientific knowledge, she could be criticised on the grounds of not defining adequately what is meant by scientific knowledge. The boundaries of empiricism are not explored and one assumes that Robinson is infering that deductive theory building is science whilst the inductive approach is not. This is where health visitors have, hitherto, seen the value of the health visiting process. By introducing a systematic, problem solving approach to practice, practice can be validated in deductive, "scientific" terms so that health visiting knowledge is seen to have professional status. For example, Hendy (1983) took a reductionist approach to the health visiting process when she stated that :

> "Through the pursuit of knowledge, the logical whole is discovered from the component parts" (Hendy 1983:197).

In so doing she proposed that "a profession must apply the highest order of problem solving to situations with its remit" (Hendy 1983:197).

Hendy recognises the potential of the health visiting process for changing professional status. However, like some other authors (e.g. Rogers 1982), Hendy has confused the issues of the perceived conceptual basis of health visiting process (problem solving) and its implementation. Hendy refers to the process as a useful means of reaching holistic care. Holism refers to a philosphy that recognises human existence as *more* than just the sum of its component parts. Thus pursuit of knowledge through Hendy's understanding of the process cannot be seen as holistic. To care for an individual or family holistically requires skill and knowledge which is not conceivably achieved by reducing the family to a set of systems or problems. Intuitive judgement and interpersonal skills are key areas which Hendy indentifies but then submerges under the need for health visiting to be recognised as a profession. Schrock (1982) has questionned the whole issue of professionalization in health visiting. If health visitors want the kind of knowledge associated with the established professions such as medicine, then Schrock suggests that this carries with it the professional mystique which leads to social control. She argues for the search for alternative strategies for validating health visiting practice. If health visitors had looked back as far as Orlando's (1961) work they would have discovered the logical and valid basis for health visiting practice which encompasses holism and values interpersonal relations, intuitive thinking and reflection as an inductive basis for developing nursing knowledge.

The relationship between Nursing Process and quality of care

Despite all arguments for and against the Nursing Process as a way of "professionalising" nursing, an important *raison d'etre* of the Process is that it will by its structured, systematic nature lead to improvements in the quality of patient care. The simplistic argument for this assumption has been that the Nursing Process provides a patient-centered, individualised approach to care as opposed to basing care on routines and tasks to be performed. However, in many ways task allocation could be seen as a very efficient way to deliver care (Chavasse, 1981). In a comprehensive review of the Nursing Process, Walton (1986) has considered in detail both the problems of evaluating a method of organising nursing activity and the research which has attempted to do so. Some of the problems associated with evaluation of practice are discussed in chapter three of this review. Therefore a selective review of the literature concerning the overall evaluation of the Nursing Process will be considered here together with a more detailed account of the studies which are directly concerned with health visiting.

One difficulty of evaluating the overall effect of the Nursing Process as a method of organising nursing care, is the establishment of objective indicators of whether or not the Process is in operation. As Walton (1986) has pointed out, there are multiple aims and objectives of the Nursing Process described in the literature and without a clear statement of what it is supposed to achieve "the further stages of evaluation are obviously jeopardised" (Cullen, 1983:5). Brooking (1988) has tried to overcome this problem through the development of a scale to measure the use of the Nursing Process. Brooking (1988) has demonstrated through comprehensive tests of reliability and validity that this 43-item scale can demonstrate the extent to which a ward environment has implemented the Nursing Process. Whilst, as Brooking acknowledges, the scale does not in itself measure quality of care it is an important pre-requisite to process-outcome evaluation studies. Brooking suggests that the scale could be adopted for use in other environments including the community but there has been

little further research in this direction to date. Brooking's scale is the only known reliable instrument for measuring implementation of the Nursing Process. This means that the majority of research which has attempted to evaluate the overall effectiveness of the process has been undertaken in the absence of any objective indicators of use. Several studies have been conducted to measure the quality of the *process* of care, using meaures such as the "Quality Patient Care Scale" (QualPacs, Wandelt and Ager 1974) and "Monitor" (Goldstone and Ball 1984) and there has been a growing emphasis on patient *outcomes* as criteria for evaluation. However, without the pre-requisite meaure of the implementation of nursing process, measurement of outcomes is fraught with methodological problems. The Nursing Process is a method of organising care and as such it is difficult to identify whether it is the dependent or independent variable in patient care. The nature of patient care requires the intervention of a multi-disciplinary team and patients responses to health and illness will vary accordingly to a multitude of factors. Inevitably, there are many areas of care which are outside the control of the nurse. Pheneuf (1987) has commented that :

> "The process of nursing care can be controlled and measurements can be trusted ; in the current state of the art, the same cannot be said for outcomes" (Pheneuf 1987:3).

Moreover, it could be argued that, in the U.K. in particular, it is too early in the history of the Nursing Process to evaluate effectiveness in terms of outcomes. There is still much to be learned about the nature of nursing and the development and implementation of theories which might form a conceptual framework for the Nursing Process before any definitive statements can be made about the effectiveness of the Process in terms of outcomes. Nevertheless, there have been reports in the British literature of the value of Nursing Process in terms of patient outcomes and some examples have been selected to illustrate the problems. For example, Miller (1985) conducted a study which looked at patient outcomes in terms of dependency levels. Using the CAPE scales (Pattie and Gilleard 1979) to measure dependency among elderly people in two geriatric wards, Miller found that there were significant differences in mean scores between patients on a traditional task allocation ward and those on a ward

where the Nursing Process had been implemented, in favour of the Nursing Process ward. Miller controlled the study for structure as far as type of patient, size of ward, admissions policy and staffing levels were concerned. The process of nursing was to some extent controllable through the structure of either Nursing Process or Task Allocation although Miller does not make it clear how these were defined or implemented. Miller, however, assigns the outcomes on patient dependency to the use of the Nursing Process as she could not identify any other major changes in the ward environment.

There are, however, a myriad of other factors which could influence patient dependency levels including input from other team members such as Occupational Therapists and Dieticians, the individual responses to their hospitalisation and the type of care received in the community prior to admission. Miller's results sound very favourable towards the Nursing Process, but in a sense they are sterile unless those who wish to follow up and implement her findings are made aware of the actual processes which lead to the lower dependency outcome. Apart from the fact that the nurses cared for 6 or 8 patients each rather than 30, we know nothing of how they assessed or how they planned their care and even less about the evaluation criteria and methods the nurses were using.

A study by Hurst (1985) evaluated the effect of the Nursing Process against task allocation and patient allocation. The study aimed to evaluate the Nursing Process on a number of criteria including patient benefit, cost effectiveness, job satisfaction and managerial efficiency, amongst others. Hurst hypothesised that the Nursing Process would be more effective on all these criteria than the other methods of nursing care. The criteria were assessed using a self-completion questionnaire administered to 135 nurses working in the specified areas with a response rate of 61 % Hurst acknowledges the weaknesses of the questionnaire design -the items were arbitarily chosen and based on anecdotal evidence and as such were invalid and probably unreliable.

Hurst's findings are mixed. In some areas the nurses' responses indicated that patient allocation was more effective than the Nursing Process -for instance in job satisfaction, patient benefit and nursing efficiency. Thus, Hurst's hypothesis could not be supported. There are many methodological weaknesses in this study which serve to illuminate the problems in evaluative research of this nature. Firstly, as indicated, the questionnaire design was inadequate and no attempt at validating it has been reported. Secondly, Hurst had no objective criteria by which to assess the method of organisation of care and thirdly whilst the outcome criteria have been outlined they have not been defined- what is meant, for example, by patient benefit? Finally, as in Miller's (1985) study, whilst claiming that the Nursing Process produces better outcomes in some areas such as personal learning, Hurst does not explore how these "improved" outcomes were achieved. Moreover, if nurses perceive patient allocation to be more effective in some areas than Nursing Process, how are the two methods being practised? Such questions remain unanswered but serve to illustrate that outcome research is inadequate if unsupported by the evidence on process.

One final piece of research selected for review in this area is that by Richards and Lambert (1987). This study differed from many others in that it was carried out in a psychiatric hospital and used patient satisfaction as the outcome criterion. The study set out to explore differences in patient's satisfaction with nursing care according to whether care was organised around the traditional methods used in psychiatric nursing (including therapeutic community, democracy, and creative therapies) or the incorporation of the Nursing Process into this approach. Thus, patients involved in the study were on the same ward and all received traditional care but some were randomly allocated to a Nursing Process group. Satisfaction with care was measured using a questionnaire administered by an interviewer. There was little indication of any reliability or validity test being carried out on the satisfaction scale, in addition to which Speedling and Rose (1985) have criticised the use of patient satisfaction as an outcome measure on the grounds that any warm, caring relationship can provide

satisfaction regardless of the way in which the care is organised. Interestingly, the authors report that very little difference was found between the two groups of patients. Their explanation for this rests on the fact that some custodial activities which nurses are bound to carry out under the Mental Health Act may be seen as non-therapeutic and also that the so-called traditional nursing care may already make a significant contribution to patient's perception of their care. Although this latter point is rejected by the authors on the grounds that there is no research to validate the effects of therapeutic community it deserves some further explanation. The study does not elucidate to what extent the two groups contaminated each other. The patients were all in the same ward and therefore presumably talked to each other and talked to nurses involved in both aspects of care. Both groups received nursing care centered around the concept of therapeutic community. This method of care suggests that a high degree of interpersonal skills are required and that the care is based on the nurse-patient relationship. It is thought provoking to consider that Orlando's (1961) original ideas on Nursing Process were centered on the dynamic nature of the nurse-patient relationship and that this could be the key to effective care whatever method of organisation is employed. As Richards and Lambert (1987) warn, it is important not to replace one system of care with another unless significant improvements can be identified. Some further exploration of the processes involved in both therapeutic community and the Nursing Process would help to establish the significance of the nurse-patient relationship.

Evaluation of the Health Visiting Process

Whilst some research in general nursing has been attempted to evaluate the effectiveness of the Nursing Process, there has been a significant dearth of similar research in health visiting. It would be true to say that whilst the Nursing Process has become an established approach to care in general nursing, its implementation into health visiting has waxed and waned. It is perhaps not surprising that very little evaluation has been carried out of the health visiting process. Much of what has been written in the health visiting process has been descriptive in the sense that it has described what the health visiting process is, how it was implemented and the type of documentation used (for example Rogers 1982, Menzies and Harrison 1985, Clark 1985, McKay et al 1988). This type of literature has given rise to debate among health visitors about the nature of a new sytem of documentation rather than the potential intrinsic value of a process of care to the client. For example, a one day conference in 1985 devoted to exploration of the health visiting process spent more time discussing the record card and how the stages of the process should be written up than on the academic debate of what the health visiting process should or could be about. One paper given by Clark (1985) explored a possible theoretical framework for implementing the health visiting process and this has been reported (Edsalls 1985) to have been well received by health visitor's attending the conference. Why in subsequent years has this not been pursued by the health visiting profession? It appears that Health Districts have largely implemented the Health Visiting Process in an unquestionning and atheoretical manner (Rogers 1982, Menzies and Harrison 1985, McKay et al 1988).

There have, however, been a few isolated attempts to explore in more depth the effectiveness of the process. Bach (1987) for example has explored the usefulness of the health visiting process within the framework of Roper et al's (1985) model of nursing. Bach's study was a six month prospective study of one case load. Evaluation was centered around the author's use and recording of the assessment using the Activities of Daily Living as prescribed by Roper et al and comparing this with the previous

documentation. One problem which arose was that the author's personal philosophy of care appears to be incompatible with the Roper Model. So that whilst the author was attempting to maintain homeostasis within the families she was visiting, the Roper Model was not useful in assessment of need related to health promotion in the family. Roper et al's model has been critiqued by Clark (1982) for its inadequacy for health visiting in that it is problem orientated rather than needs based and is essentially designed for care of the sick individual not healthy families living in the community. Bach (1987), however, found that some aspects of the model were useful in that the assessment period sometimes helped in the identification of physical needs that might otherwise have been overlooked. Overall Bach concludes that using the Health Visiting Process within a framework of care facilitated the identification of health needs, allowed for a systematic goal-orientated approach to planning, provided greater opportunities for health teaching and a means of closer observation of families with particular concerns.

Candlin's (1990) study of the Health Visiting Process in the assessment of the elderly raises questions in relation to process and outcome. Candlin has attempted to develop a reliable assessment instrument for use by health visitors whose main client group are elderly people. Whilst considerable time and effort has been put into developing the instrument, the evaluation of its success appears to be weak. Outcome measures were the reactions of clients, health visitors and doctors to the tool which were, on balance, favourable. However, whilst positive claims for the clarity and comprehensiveness of an assessment tool are valid they do not in themselves validate the usefulness of the instrument. In other words, there is no evidence presented on whether the instrument truly measured the health needs of the elderly and whether action based on this assessment was appropriate. Candlin (1990) concludes that the success of the instrument lies in the data she presents on the number of needs identified and the number of instances of advice given. Since the instrument itself is essentially a check-

list this evaluation appears to be limited by the lack of consideration of the processes involved in carrying out an assessment.

A study by Colliety (1988) attempted to evaluate the Health Visiting Process over a two year implementation period. One aspect of particular interest to the author was the effect of the process on health visitor/client communication and client satisfaction. This area was explored by interviewing cohorts of parents over the implementation period. Interestingly, the approach chosen to measure health visitor/client communication was a quantitative analysis of contacts sought by the client with the health visitor at various stages of child development. Colliety found very little difference in the number of contacts with the health visitor between those interviewed during the non-process period and those interviewed post-implementation of the Health Visiting Process. There is no attempt to explore the content or quality of these contacts so that whilst the Health Visiting Process appears to make little difference to the clients seeking advice from a health visitor the study reveals nothing about the nature of the contact and therefore of the impact of Health Visiting Process on communication or client participation.

Communication as a central feature of the nursing process has been recognised by other authors, such as Ward (1988). Ward is interested in the sociolinguistic perspective of communication and hypothesises that the use of the nursing process could improve nurse-patient relationships and particularly client involvement in decision making through an understanding of the sociolinguistic approach to communication. Ward has carried out a pilot study which examined features influencing the communication process. These factors were explored from the perspectives of both clients and nurses. The method employed was a series of inventories/indexes consisting of phrases or scenarios which respondents where asked to either rank or explain. The overall findings indicated that there was little agreement between nurses' and clients' perspectives of factors such as "expectations of hospitalisation" and "selecting verbal

responses to clients" Ward is carrying out further work on tape recorded interviews of the nurse/client interaction in order to look more closely at the links between sociolinguistics and the Nursing Process.

Whilst it would appear that this type of research is central to the practice of health visiting in which the main activity is the health visitor-client interaction there has been little attempt to date to investigate in depth the possible effect that the Health Visiting Process could have on the health visitor-client relationship and ultimately on client participation.

One of the main aims of the current study therefore is to analyse extensively the nature of the health visitor-client interaction and the impact, if any, of the Health Visiting Process on client participation.

Chapter Two

Exploring Health Visiting Practice

Introduction

There is a need to enhance understanding of the practice of any professional group. Qualitative studies of the nature of practice can feed into evaluative studies of how well the practice is carried out. Description and evaluation of any profession can thus serve to increase the academic and public understanding of a profession and also supply data which can be examined in terms of public and professional accountability. The question 'What do Health Visitors do?' has been repeatedly addressed. Decision makers and those who allocate resources need to know that funds are being directed in an efficient way and policies appropriately implemented. Evidence of what it is that health visitors do in practice can lend support to proposals for policy change, for example in educational terms (Sefi 1985, Montgomery-Robinson 1987) or in social policy (Mayall 1988). The development of health visiting as a profession can only occur when a full understanding of current practice is reached and this demands a continuous exploration and description of practice in the light of educational and philosophical change within the profession. For example, a study by Clark (1973) described the health visitor as a "family visitor" in the light of the Jameson Report (MOH, 1956), a later study by Montgomery-Robinson (1987) found little evidence for the health visitor's attention being directed at the whole family with the focus being on mother and baby. This apparent change in practice could be accounted for in the light of reports such as the Court Report (DHSS 1976) which emphasised the need for special attention to child care. More recent reports on community care (DHSS 1984, DHSS 1986, DHSS 1986A, DOH 1990) have emphasised the need for a more consumerist approach and a major aspect of the present study will be to analyse health visiting practice in view of this ideological trend.

Chapter Two

Description and evaluation of health visiting practice enables health visitors themselves to analyse, critique and improve on their own methods as suggested by Warner (1984). In theory, it also enables recipients of the service to have access to information about what it is that health visitors do and to use it to develop their ideas about the kind of service they desire.

Such studies of health visiting practice fall into both descriptive and evaluative categories and this chapter examines the descriptive evidence which is available in this area, and explores the need for further research in the field. Similarities and discrepencies with some other studies of related professional practice outside of health visiting will also be explored.

Studies of Health Visiting Practice Undertaken Prior to 1980

Health Visiting by its nature has always been practiced largely outside of the public gaze. The emphasis on home visiting and the one-to-one approach has ensured that the actual processes which constitute the activity of health visiting have been private whilst the primarily interventionist nature of the work (Mayall and Foster, 1988) has ensured that the profession of health visiting has only had to be accountable to itself rather than respond to public demand. It has been argued that health visiting practice has been socially constructed (Montgomery-Robinson 1987, Mayall and Foster 1988) by British social policy regarding child care in the under fives. An example of this is the taxation on work place creches. Such policies have ensured that child rearing takes place largely in the home away from public scrutiny. Since the emphasis of health visiting is primarily on the health and care of children under five (DHSS 1976), it therefore follows that much of the work of the health visitor remains a private activity. However, interest in what health visitors do with their time has been expressed by the profession over the past 25-30 years. It has been the very nature of the activity itself which has made it methodologically difficult to produce evidence on, not only what health visitors do, but how they do it.

Chapter Two

Following the National Health Service Act (1946) it became evident that there was a need to clarify the role of the health visitor. A working party was established and its report, An Inquiry into Health Visiting (Jameson Report), was published in 1956 by the Ministry of Health. One of the main conclusions of the Inquiry was:

> "In the ordinary course of her work, she (the health visitor) could be in a real sense a general purpose family visitor" (MOH, 1956: para 10).

Her function was defined as "health education and social advice" (MOH 1956: para 302).

A study conducted by Clark (1973) aimed to explore the concept of the "family visitor" by attempting to describe the content of the home visit. Clark's work was informed by an earlier American study by Johnson and Hardin (1962) which investigated the content and dynamics of home visits by public health nurses. This American study therefore deserves review since it is relevant to both Clark's work and to the current study. Johnson and Hardin (1962) analysed 287 home visits carried out by 157 public health nurses. The method employed by the researchers was audio recording of the home visit and observation by the researcher. Such a method was justified by the authors on the grounds that:

> " Such role aspects as health appraisal, health teaching, giving emotional support or influencing changes in patient behaviour can be successfully accomplished only through communication with the patient"
> (Johnson and Hardin, 1962 : 9)

The only way to accurately record such communication processes is through audio or video recording. For this reason, a similar data collection approach was adopted in the current study.

Johnson and Hardin presented a detailed analysis of the interactions recorded. This involved abstraction of topics from each interaction and classification of the interactions between nurse and patient into "dimension of verbal involvement", "content" and "dynamics". The study was carefully conducted with close attention to

reliability and some interesting conclusions are drawn. Firstly, the researchers found that the topic of each interaction was largely controlled by the public health nurses who tended to initiate two out of three topics. However, they question the tendency to label nurses as domineering as their analysis suggested "the delivery of nursing care ...is affected by difference in opportunities conditioned by the variable communicative norms of households "(Johnson and Hardin, 1962 : 51).

In other words, the authors were suggesting that the nurses often had to accept a directive role because of the communcative styles of the families they were visiting. They justify this assertion on the basis of the quality of client reponses. However, there is limited evidence from this study to suggest that the nurses were adopting a facilitative style which might have enabled families to be more responsive.

One conclusion drawn by the authors of this study which was significant for Clark's (1973) work was:

> "It is frequently assumed that the family rather than the individual is the unit of attention of the public health nurse. In reality, however, the rationale open to the nurse for entering a household is normally one problem centering on one person"
> (Johnson and Hardin, 1962 : 51)

Although the work of the public health nurse can, in the USA, be said to be different from that of the health visitor in respect of the greater emphasis on physical care, there are nevertheless similarities in the way that their work is organised, primarily through visiting in the home.

Clark (1973) collected data from 2,057 visits which were analysed in terms of the pattern of the home visit, the content of the visit and the client's part in the interview as well as other variables such as characteristics of the health visitor and her career pattern. Among her findings Clark found that 63.5% of visits were health visitor initiated, indicating an interventionist approach and whilst 80% of the visits were planned it appears that this referred to planning by the health visitor alone not planning in consultation with the client. Clark also found that 40% of topics were

initiated by the client - this is in contrast to Johnson and Hardin's study in which only 30% of topics were client initiated.

Clark's (1973) British study of health visiting took, in a sense, a backwards step from the American study (Johnson and Hardin 1962). Whilst recognising the value of Johnson and Hardin's method, Clark claimed that she did not have the technological resources available to her and the study therefore relied on the self-completion by health visitors of "visit schedules" which were based on Johnson and Hardin's classification. Self-reporting methods can be criticised on the ground of subjectivity, particularly in respect of the health visitor's assessment of the verbal involvement but also in respect of the time lapse between a visit and completion of schedule, over which the researcher had no control. This could affect the accuracy of recording and also the possibility that the health visitors record what they thought the researcher wanted them to report. Neither were the self-completed schedules validated by any data collected from the clients . It is arguable whether health visitors self-reported content of their visits has any value whatsoever in the absence of any validating material.

Clark recognises the limitation of her study but in her conclusions she uses the findings to endorse the concept of the family visitor:

> "Whatever the need which a family may present, the health visitor attempts to meet it..."
> (Clark, 1973: 105)

It could be argued that Clark has over-extrapolated from her findings in order to reach this conclusion. Later studies (Sefi 1985, Montgomery Robinson 1987) refute this finding and throw further doubt on the reliability of Clark's (1973) work. These studies are considered in more detail later in the review.

Following this study of health visiting activity, Clark (1981) carried out a comprehensive review of all British studies between 1960 and 1980 which investigated the nature of health visiting. Because this review is detailed and easily accesible it was

not considered necessary by the current researcher to re-review these studies in any depth. Clark concludes that although the review is interesting for its own sake and helps to dispose of the myth that "nothing is known about the work of health visitors", "it's usefulness, particularly for strategic planning purposes is limited" (p87). This is largely due to the studies under review being rather piecemeal without a sense of accumulation of information or building on previous knowledge. Therefore for the purposes of the current study, just one of the studies included in Clark's review will be addressed. The studies described in the remainder of the chapter will be those conducted after 1980.

One important study also reviewed by Clark (1981) which is of some relevance to the current investigation is that carried out by Watson (1975). Watson's work was one of the first British studies of the home visit to address the methodological issue of self-reporting and to shift the balance towards a more reliable technique, that of direct observation of health visiting in the home. Watson chose to conduct an observation and time study in the city of Aberdeen of 564 visits by 21 health visitors. The researcher accompanied health visitors on all their visits over a four day period and observed and recorded all activities using a stop watch to calculate the duration of each activity. Watson categorised her findings into "activity" and "topics". Her main findings were that in 52% of visits "listening" was the main activity, in 22% of visits "questioning" was the main activity in 13% of visits "social chat" was predominant and in 6% of visits the main activity was "giving information". Topics related to childcare were the main source of discussion in 43% of visits. Watson concludes that:

> "the overall impression created by the findings on dominance is of a professionally based
> service in which a striking degree of egalitarianism
> has been achieved."

Watson's findings are interesting in the light of later studies (Sefi 1985, Montgomery Robinson 1987) which have found little evidence for equality in the health visitor client relationship, these studies having adopted more rigorous methods of analysis.

Similarly, a study of health education interactions between nurses and clients (Macleod Clark et al 1990) has shown that listening is less obvious than questioning or advice giving. Macleod-Clark's (1990) study involved detailed analysis of tape recordings and therefore gives a more reliable indication of the activity of listening. Although Watson's study was carefully conducted it could be argued that time is not a sufficient measure of what constitutes the process of relationship building and that more detailed analysis of an interaction is required in order to surface these processes. For example, what is Watson's interpretation of "Listening"? It is not clear whether this represents a period of complete silence by the health visitor or a period where verbal and non-verbal signs give both client and the researchers the impression that the health visitor is listening. Alternatively, the researcher's interpretation of listening may differ to that of the client. In terms of timing the activity of "listening" must present problems of reliability.

In summary, earlier studies on the nature of health visiting practice have reached questionnable conclusions. It seems likely that the research method may account for much of the disparity with more recent work. For example Clark's (1973) use of self-completed reports of visits by health visitors led her to conclude that health visitors deal with the needs of the whole family. This belief is now in dispute. Equally, Watson's (1975) study failed to address the qualitative nature of the health visitor/client interaction and this casts doubt on her conclusions about such encounters.

Studies relevant to health visiting practice

A number of studies in other disciplines such as medicine and social work have informed and influenced later research into the qualitative aspects of the health visitor client interaction. These related studies therefore demand some attention.

Twenty two years after Johnson and Hardin's (1962) study Clark (1984) described audio recording as a method of collecting data on the health-visitor client interaction. Although the method had been used in studies of related disciplines (Byrne and Long 1976, Baldock and Prior 1981, Tucket et al 1982 and Macleod-Clark 1982) Clark suggested the study of the health visitor-client interaction posed special problems as

> "the talk which is exchanged between the health visitor and client, especially during home visits, is relatively unfocussed and unstructured " (Clark, 1984 : 5).

Baldock and Prior (1981) had, in fact, reported on an analysis of conversations between social workers and clients in which they suggest the interviews were often unstructured and had "a curiously ramshackle air" (p 35). This suggested that the health visiting interview was not unique in its style and was amenable to analytical approaches demonstrated by research in related areas which would shed new light on the nature of health visiting practice. A study of the talk occuring between doctors and patients (Byrne and Long 1976) had considerable influence on subsequent studies. Byrne and Long analysed the interactions occuring over 2,500 medical consultations in General Practice and developed a scoring system for rating the interactions according to six identified phases of the interview: relating to the patient, discovering the reason for the patient's attendence, conducting verbal or physical examination or both, consideration of patient condition, treatment or Investigation, termination.

Within each of these phases interactional styles were identified, for example clarifying and direct questioning, and the styles were numbered from 1 to 7 accross a continuum of doctor centredress (1) to patient centredress (7). This categorisation was then used to score the interaction and used as an indicator of the doctor's overall style. The study

revealed that the doctors generally tended towards a doctor-centred approach and the authors put this largely down to the medical model of education and other factors such as short consultation time in busy city practices. However, an inherent problem which arises from this study is the scoring system which depended on raters identifying the style and assigning the appropriate style number which is the score. A style which fell between two styles was assigned a fractional score (e.g. 2 1/2). The lack of information regarding the reliability of this rather arbitary scoring system suggests that it is not necessarily a useful instrument for studying professional-client interaction in other disciplines. Although Baldock and Prior (1981) used the Byrne and Long analytical technique they give very little attention to their analytical framework and it is therefore difficult to make an objective assessment of the conclusions they reach about social work interviews. They suggest that social workers are more client centered than doctors and yet use controlling mechanisms in a latent fashion, which Baldock and Prior argue is skilled practice. The work has been criticised by Clifton (1981) on the grounds that a non-directive approach which leaves the client "confused, and indeed deceived" (p42) cannot be described as skilled if the skills are not in line with the meaning that clients assigned to social work help. This criticism has implications for the current study - can health visiting practice be described without some understanding of the client's interpretation of events or their perception of the activity of "health visiting"?

Tucket et al (1982) addressed this issue when they investigated the GP - patient interaction in terms of the integration of lay and medical frameworks of knowledge during an educational exchange. The objective was one of exploring informed decision making among patients in general practice and the analysis was based on 405 audio recorded consultations and subsequent interviewing of a sample of 328 patients at home. The research was rigorous in its analytical framework and reliability testing and the conclusions have considerable bearing on the currrent study. Although Tucket and colleagues identified nine positive elements of the consultations (e.g. patients

could generally correctly interpret the meaning of important points made about their condition) they also identified 11 negative elements (e.g. an absence of reactive justification) i.e. doctors justifying their action in response to patient cu es on demand which led them to conclude that overall

> "consultations are not enabling patients to make informed decisions about their health care, and are not being conducted to use this interactive potential"
> (Tucket et al, 1982 : 11).

Studies Examining Health Visiting practice from 1980 - present

Watson's (1975) study of health visiting practice preceded the development of a series of studies in the 1980's which have employed direct observational methods of examining health visiting and have moved away from an emphasis on quantitative methods towards a qualitative analysis of health visitng drawing on the use of more sophisticated methodological approaches.

The studies described previously raise the question that if the health visitor...

> "by promoting health and health policies, empowers people to take responsibility for health as individuals, families and communities, and thereby helps to prevent and minimise the effects of disease, dysfunction and disability"
> (HVA 1985)

to what extent is she using the potential of the interaction to achieve this?

Previous studies of the relationship between health visitors and clients have reached different conclusions. Warner (1984a) conducted a study of the interaction between health visitors and clients in the clinic situation. She captured audio recorded data of 229 interactions. Warner expressed her interest as being centred around the "ways in which practitioners fit advice to individual clients" and was more interested in the dynamic aspect of the interaction than in content. This study is different to other studies of health visiting by virtue of the contextual issues. Earlier in the chapter, the

private nature of the home visit was addressed. Clearly, the clinic is a very different situation in which the health visitor is playing a responsive role in that the client comes to her, whilst child care practices and the health visitor's response to them is much more in the public domain, depending on environmental factors in the clinic itself. Thus, the clinic consultation is more akin to the medical consultation in that the interview is usually limited in time, the client attends for a specific purpose which may be known to both health visitor and client and there is likely to be a public element such as a waiting room and a receptionist which may have bearing on who attends the clinic and what they are prepared to divulge. Warner gives examples from her analysis of how health visitors use interactional techniques to both encourage clients to ask the "right" questions and to move towards mutually achieved goals. (Warner 1984). The techniques she describes include offering the mother objective evidence, diminishing the mother's responsibility for an observed problem and building on the mother's exisiting knowledge and practice. In much the same way as Baldock and Prior (1981) described the hidden techniques that social workers use to control their clients, Warner suggests that health visitors pursue their plans with "remarkable tenacity" and her descriptions of interaction indicate that the techniques used by the health visitors were covert. The author concludes that plans were

> "interactionally achieved during encounters as the health visitor modified her plan minute by minute to suit the client's readiness to co-operate with the plan"
> (Warner 1984 : 244).

The overall impression gained from this study is that although Warner perceives the goals to be "mutually acceptable" and achieved by "negotiation" there is little evidence for goals being openly negotiated and a lack of client follow up in the study leaves room for more speculation as far as the client's perception of the goals is concerned. In contrast, a study by Macleod Clark et al (1990) of health education interventions in relation to smoking cessation between health visitors and clients, found little evidence of mutual planning. The context was different to that of Warner's (1984) study since the

emphasis of the interaction was on one specific area of health education (smoking) and was carried out in a variety of settings including the home and clinic. However, using on analytical framework previously developed by Macleod-Clark (1982), it was possible to demonstrate that goals were rarely mutually negotiated and that health visitors tended to use non-participative styles such as leading questions and prescriptive advice to pursue their plan of smoking cessation. This study followed up clients at six months and one year after the consultation and some tentative conclusions were reached regarding the relationship between the process and outcome of the interaction. It appeared that a positive behaviour change (i.e. cessation of smoking) may be related to communication styles in the initial interaction. For example, in successful interventions there was more likely to be an egalitarian relationship between health visitor and client and the health visitor tended to use techniques such as open questioning and encouragement more frequently than in interactions where behaviour change did not occur. Both Warner's (1984) and Macleod Clark et al's (1990) study have important implications for the current study as negotiation of goals must form the basis of client participation. Freeman (1987) also describes health promotion talk between doctors and patients where it is again evident that the professional and client rarely share a frame of reference.

Clark (1985) first undertook a study of the process of health visiting which differs from those already described and subsequent studies. Clark attempts to elicit a theory of health visiting from the data rather than describe what the nature of health visiting is. However in so doing, Clark encountered some methodological problems.

At the outset of the study one of the stated aims was to:

> "describe the content, structure and process of the interactions between health visitor and clients which constitutes health visiting practice, in such a way as to enable the identification and analysis of health visiting skills and outcomes"
> (Clark, 1985).

In order to achieve this, Clark audio recorded 308 home visits by health visitors to mothers and baby's from birth to one year of which sixty were selected for transcription and analysis. There is little information given about how these tapes were selected which could mean that the researcher was biased in her selection. The health visitors involved managed their own recording equipment as participant observation was not possible. Inevitably, some data was lost but an advantage of the study was that both health visitor and client were able to familiarise themselves with the recording process over the twelve month period and Clark suggests this could enhance the "normality" of the interaction although previous research (Byrne and Long 1976, Baldock and Prior 1981, Macleod-Clark 1982) has suggested that audio recording appears to have a negligible effect on the flow of the interaction.

Clark considered previously tried and tested methods of interaction analysis such as Bales Interaction Analysis (1950), Byrne and Longs (1976) analysis of G.P/patient interaction and Macleod-Clark's (1982) analysis of nurse-patient interaction on a surgical ward. For the most part, Clark found these methods insensitive and inappropriate to health visiting situations although Macleod-Clark's (1982) method appeared to offer a way of approaching health visiting. Clark identified the "episode" as defined by Johnson and Hardin (1962) as the unit of analysis and indentified thirty topics within eight groups and six health visiting 'skills.' The 'skills' were: eliciting information, assessing/analysing, reassuring/supporting/informing, advising, maintaining the interaction, practical procedure.

A reliability study at this point yielded less then 60% inter-co der agreement and Clark decided that a "fundamental reappraisal of the project was required" (p106). It is not difficult to gauge why Clark had such difficulties with this stage of the analysis. It could have been the enormity of the task she had set herself by attempting to analyse health visiting practice on only six pre-defined dimensions or the framework itself may have been questionable. To what extent, for example, were the health visiting

'skills' derived from the data itself? There is an ambiguity between skills such as "eliciting information" and "assessing" and the category "informing" sits uneasily with that of "reassuring/supporting".

Whatever the reason, Clark concluded that

> "A major problem which emerged from an attempt to construct categories systems for the data in the present study was the lack of a theoretical framework in health visiting"
> (Clark, 1985 : 106).

Clark then searched for a qualitative method of analysis which would enable her to derive some theoretical constructs from her data. She turned to Glaser and Strauss's (1967) strategy for qualitative research: Grounded Theory. Although Clark describes her subsequent analysis in line with the principles of grounded theory there are several major flaws with this approach as far as Clark's study is concerned. Firstly, Glaser and Strauss (1965) describe the constant comparative method whereby the analyst by comparing incident for incident in the data establishes conceptual categories which serve to explain the data. Once categories start to emerge from the data they are used in order to direct further data collection. Glaser and Strauss (1965) describe this process as "theoretical sampling" :

> "the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them in order to develop this theory as it emerges"
> (Glaser and Strauss, 1965).

Theoretical sampling is distinguished from statistical sampling in that it is not numerically predetermined, rather it relies on the emergence of categories from the data and categories are said to be saturated when no new data emerges. Theoretical sampling can only be complete when all the categories are saturated.

In Clark's study the data were collected some years before a grounded theory based analysis was attempted and the proposed theoretical model cannot therefore be truly

grounded in the data since neither comparative induction of categories nor theoretical sampling were employed, although Clark claims to have compared emerging theories with her practice at the time.

Secondly, Glaser and Strauss (1967) have stated that one should study an area

> "without any preconceived theory that dictates, prior to the research, 'relevancies' in concepts and hypotheses".

The point about grounded theory is that substantive concepts and hypotheses should emerge from the data enabling substantive theory to be developed. Clark's proposed model of health visiting relies on Neumans (1972) model of nursing which is itself derived from Systems Theory (Von Bertalafny 1968). The study cannot therefore be said to have generated substantive theory as described by Glaser and Strauss (1967).

Clark's model does, however, offer an attempted explanation of health visiting practice. The model is built on five concepts suggested by Neuman (1972) which form the metaparadigm of nursing i.e.: nurse (health visitor), patient (client), nursing (health visiting), environment and health. Using the framework of Systems Theory, Clark defines her model of health visiting as an open system in which the client is the family who is vulnerable to stressors with which the health visitor helps the family to cope through different levels of preventitive care, thus maintaining the stability of the system:

> "the health visitor helps to maintain and improve the dynamic equilibrium of health by heading off stressors and building up the client's ability to cope and facilitating entry of beneficial input" (Clark, 1985).

It is questionnable whether a Systems approach is appropriate to health visiting as there is room for debate about whether a family or an individual can be broken down into systems. In conclusion this complex, at times enigmatic study, appears to endorse an interventionist approach to health visiting (i.e. the health visitor reacting to vulnerabilities and problems within the

family) rather than a participative approach which is responsive to client need. The concept of the "family visitor" as described in Clarks earlier work (1973) is also perpetuated.

Subsequent studies of health visiting practice have thrown a different light on the notion of the "family visitor" and give an arguably more illuminative picture of health visiting practice.

Sefi (1985) carried out a detailed study of health visiting in order to "find out what occurs between the health visitor and mother during a routine visit in the mother's home" (p33). She collected audio recordings of all visits to ten new mothers by five health visitors from birth of the baby to eight weeks. From a total of forty-six tapes, nine tapes relating to the primary visit (i.e. ten days post-natally) were selected for transcription and analysis. Sefi posed three main research questions:

> What is the extent to which the interaction consists of advice giving or support?
>
> Is the nature of the interaction professional/client in orientation or one of befriending?
>
> What kind of strategies are used in the giving of advice? (Sefi 1985 : 35-36)

Sefi subjected her data to both quantitative and qualitative analysis. The quantitative analysis revealed that health visitors spent proportionally more time in baby orientated topics than mother orientated topics. Also, in contrast to Clarks 1973 study and Watson's 1975 study, the health visitors in Sefi's investigation opened and closed *all* topics. This tends to suggest a controlling aspect of style directed more at problems than relationship building.

Sefi took an ethnomethodological approach to the qualitative analysis and turns to conversation analysis as described in Heritage (1984) for her analytical framework. Although the transcriptions were carefully carried out according to the notation of the school of conversation analysis, Montgomery-Robinson (1987) has criticised Sefi on

the grounds that she (Sefi) does not make it clear where she wishes her study to stand methodologically.

Indeed, since Sefi did not elaborate on the ethnomethodological field of research nor provide any substantive justification for using conversation analysis it is not entirely clear whether her detailed transcriptions were intended to advance the knowledge of how conversation is constructed or the nature of health visitor-client interactions. Sefi did, in fact, make some detailed observations on the structure of the health visitor client interaction but it is arguable whether conversation analysis per se, which as Sefi's takes pains to point out is a costly and time consuming process, was the only method appropriate for analysing these data. For example, Sefi identified the Question/Answer/Third turn sequence as a construct of health-visitor/client talk. She identified that the third turn "overwhelmingly consists of the health visitor delivering either advice or information or endorsement". She analysed this third turn in terms of it being either authoritative or affiliative and concluded that, in general, it tended to be authoritative. It is via this technique that Sefi asserts that health visitors get through all their business. Sefi concluded that the health visitor maintains a controlling influence over the interaction with clients and that

> "In general, the consequences of the assertion of professional knowledge was to cast the mother in the role of the uninformed recipient of information and as a person whose competence in the management of a baby could not be presumed"
> (Sefi 1985 : 83).

Alternative analytical techniques may well have revealed similar findings such as that taken by Macleod-Clark (1982) in her study of nurse-patient interactions using specific communication skills as a framework such as open questions rather than the construction of the conversation as a whole.

Although Sefi does not investigate the client's perception of these interactions, a study by MacIntosh (1986) investigated the impact of the interactional style of health visitors on a sample of mothers in Scotland. Almost two thirds of the mothers in this study complained of health visitors being too directive and as MacIntosh notes:

> "the resentment which a directive approach engendered was exceedingly damaging to the health visitor client relationship and greatly reduced their service's effectiveness" (MacIntosh 1987 : 7).

Although MacIntosh's study relied on the mother's reports of the health visitors interactional style, it does appear to compliment Sefi's (1985) findings. Both studies isolated instances of the health visitor adopting an affiliative style or being identified by the client as "friendly" but these were in the minority.

Montgomery-Robinson's (1987) work further elaborated on the nature of the interaction between health visitor and client. She too concentrated on the primary visit and the study is based on twenty eight such encounters. Unlike Sefi (1985), Montgomery-Robinson (1987) places her study firmly in the field of ethnomethodological ethnography and as such her analytic categories using conversation analysis techniques (Heritage 1984) are derived from the data and the author avoids pre judging her data. She describes her task as not one of judging health visiting but of describing how the participants have defined and displayed health visiting through the selective use and recognition of particular elements of social interaction. In so doing she defined some categories of talk within which the health visitor/client encounter is managed and from which some inferences may be drawn. An example of one of Montgomery-Robinson's defined elements of social interaction is the "extended turn" - this usually consisted of an explanation or monologue by the health visitor or an account or story by the client, although story telling was rare. Montgomery-Robinson suggests that differential use of such features means that although they may contribute equal amounts of talk, the participants are not

contributing equally to the interaction. Another element of the interaction was closure and on this point the author notes that

> "the lack of an explicit agenda, coupled with an understanding on the part of the mothers that the health visitor has some plan or purpose, makes it very difficult for the mothers to predict when closing is likely to occur"
> (Montgomery-Robinson, 1987 : 170).

These observations would suggest a controlling role by the health visitor and the author does describe an assymetrical relationship. Montgomery Robinson also makes observations on the role of other family members. She suggests that the limited contribution of fathers and grandmothers and their expectation that the mother and baby would be the focus of attention implies that in many cases the concept of the family visitor cannot be upheld. Although Montgomery Robinson's (1987) study gives new insights into *how* health visitors manage home visits and serves as a subject for academic debate it is difficult to identify its practical contribution to health visiting practice as she is reluctant to draw inferences for practice from the study. The author recognises this and draws upon Atkinson and Drew (1979) to justify this position maintaining that a willingness to make ambitious claims on the basis of preliminary research and the pursuit of practical goals has characterised much nursing research. However, she points to its potential use for influencing policies affecting the structure of health visiting and for in-service training and educational purposes.

Summary

To summarise, there have been a series of studies of health visiting practice and practice in related disciplines carried out over the last 25 years which yield a variety of perspectives on the nature of the health visitor/client interaction. Most of the studies conducted prior to 1980 have been fraught with reliability problems as indirect methods were employed and data accummulated which depended largely on self-reporting. Clark's (1973) study endorsed the concept of the family visitor whilst Watson's (1975) observation and time study was one of the first to use direct methods of observation. Watson suggested that much of the health visitors time was spent

listening. However more recent studies employing the direct method of audio recording health visitors/client interactions (Sefi 1985, Montgomery-Robinson 1987) have tended to refute the accuracy of the family visitor concept, the health visitor as listener and the egalitarian nature of the interaction. Few studies to date have attempted to explore the client's perception of an interaction and MacIntosh's (1987) work relies on the client's reports of the health visitors interactional style.

Consensus of findings from the studies to date suggest that health visitor interactions are lacking in client participation. Apart from Watson's (1975) study most of the studies discussed in this chapter have produced findings which support the view that the health visitor largely controls an interaction. This process clearly requires further exploration. Current developments in nursing are focussing on a more participative approach to health care (RCN 1988, HVA 1988). However, these developments have complex implications associated with a lack of research and poorly articulated philosophical frameworks. As Fahrenfort (1987) has pointed out patient emancipation through education ranges from giving information to increase compliance to advocacy of "patient power" through recognition of the patient as an equal. Both extremes are problematic - compliance is a medico-centric concept which is almost antithetical to participation whilst the notion of patient power is very difficult to operationalize in a health system in which medical control still dominates. Nevertheless, protagonists of patient activation in the nursing field have made proposals for future practice which draw on these ideas of participation. The Health Visitors Association (1988) for example produced a document which expounds the role of the Health Visitor as a facilitator in community and one-to-one participation. Whilst the document closely examines concepts such as need, community and participation and succeeds in promoting the way forward for Health Visiting, it does little to address the different skills and ideologies that Health Visitors may need to adopt in order to introduce this change into their practice. Likewise, the Royal College of Nursing (1988) propose recommendations for the future of health care among which is found:

> "All parts of the Health Service... must alter their procedures and attitudes to facilitate the development of consumer opportunities and devices."
> (cited in Lampada, 1988).

and that:

> "The Health Service must undergo a consumer revolution with patients given far greater choice over where, when and by whom they are treated."
> (Ibid.)

The recommendations proposed by the RCN (1988) are within a narrower frame of reference of participation than that of the HVA (1988) in that it is conceived in terms of choice and greater access to information rather than acknowledging the power and equality of the consumer. The RCN report is similar to that of the HVA is that it gives very little guidance on how nurses are to be involved in achieving these recommendations. Even less information is provided by the Department of Health (1989) in its strategies for nursing. Among the targets for practice is included:

> "The views and wishes of consumers should be taken into account in all decisions on the provision and delivery of health care"
> (Department of Health p.32)

There is no discussion on how nurses are to achieve this aim.

A particular concern of this project is to examine different methods of health visiting in order to explore the possibility of ideological frameworks of practice influencing client participation in the interaction.

In order to address this area it is essential to attempt to access both the clients perceptions and interpretations of events and the health visitors' perception of the visit. In this way interactional material can be validated. It should also be possible to triangulate the analysis - an approach which has not, apparently, previously been attempted in studies of health visiting practice.

Chapter Three

The Evaluation of Health Visiting Practice

Introduction

This chapter will explore the important issue of evaluating the practice of health visiting. In chapter two descriptive studies of health visiting practice have been discussed which were perecived to be more concerned with the *process* of health visiting. In this chapter, the problems of measuring the *outcome* of a preventive service will be discussed alongside the research which has attempted to evaluate health visiting interventions both epidemiologically and experimentally.

One of the main goals of health visiting is to encourage good health through preventive and educational action. CETHV (1977) defined health visiting as:

> " planned activities aimed at the promotion of health and the prevention ill-health" (CETHV 1977 : 8)

Luker (1985) has suggested that health visitors often assume that the results of such activities are intangible and elusive and as such cannot be measured. However, there is little point in purporting to carry out professional activities if some indication of the effectiveness of those activities cannot be given. Luker (1985) also draws attention to the difference between evaluation and evaluative reseach. As she points out, evaluation can be a subjective judgement whilst evaluative research necessitates the statement of criteria against which either the process or outcomes of practice can be measured. Health visitors may use evaluation as part of their individual practice whilst not being involved in evaluative research. This chapter therefore addresses evaluative studies of health visitor practice.

Evaluative research in health visiting

Evaluative research of professional practice can be directed at the process of the practice or its outcome. Donabedian (1968) was one of the earliest proponents of evaluating the process of care. He maintained that in relationships as complex as that between care provider and client, health outcomes could not be disentangled from the

interaction between the actors. Donabedian (1968) also emphasised that health care outcomes cannot be fully understood without first exploring and explaining the processes of the client-provider interaction. Only through such studies can quality of care be assessed and maintained. The model Donabedian proposed was generated in order to evaluate the process of medical care and addresses the doctor-patient encounter in a period of sickness but he recognises the broad nature of health care and urges health care workers to see the issues within the context of a wider health care arena. Thus, Donabedian's approach to the evaluation of care can be seen as being relevant to health visiting. Donabedian (1968) arugues that quantitative scales cannot fully represent the dimensions of care adequately and that in studies of the process of practice it is therefore more appropriate to identify prevailing patterns and specific missing dimensions. A problem for health visiting arises here in that there is not, as yet, a recognised standard of practice against which to compare these prevailing patterns. Therefore, subjective judgements have to be made about what is deemed to be "good" practice and what is missing from practice. The studies discussed in chapter two on the nature of health visiting are working towards building up a framework of ideal health visiting practice. It is, perhaps, too early in the history of health visiting research to suggest a standard although there are emergent themes and patterns which suggest that practice should be client centered, faciliative rather than authoritarian and responsive rather than interventionist (Sefi 1985, Montgomery-Robinson 1987, Mayall and Foster 1988).

Bloch (1975) has challenged Donabedian's (1968) proposal that evaluative research is based *either* on process *or* on outcomes. Bloch (1975) suggests that the representation is inadequate because a third type of research exists: the study of the relationship of process to outcome.

> "In process evaluation one examines and makes a judgement about what is done by the care provider. In outcome evaluation one examines and makes a judgement about the achievement of patient-orientated objectives. The results of the latter, however, can be dangerously sterile, because when process is not also examined one cannot know what caused the favourable or unfavourable outcomes."
> (Bloch 1975 : 258).

Process studies of health visiting have already been discussed in chapter two and therefore what follows is a review of 'outcome' studies which have attempted to measure the effectiveness of health visitng practice.

Outcome Studies related to health visiting

Outcomes of health care can be understood in a number of ways: patient compliance with treatment, client health status, client behaviour and client satisfaction. In the medical tradition, compliance has been associated with adhering to treatment regimens and in this sense is not relevant to health visiting since, by definition (CETHV 1977) health visitors are involved in prevention not treatment. However, it could be argued that clients can "comply" with preventive advice such as advice to stop smoking and in this sense compliance studies may be relevant. However, the desirability of health visitors expecting clients to comply with prescriptive advice is questionable. Studies of client health status, behaviour and satisfaction all have relevance to health visiting practice. The process of relating health visiting practice to client outcomes raises problems with how outcome criteria are defined. For example, Bloch (1975) has suggested that client outcomes are influenced by factors such as other health care workers, particularly physicians and that it is therefore extremely difficult to define outcome criteria which can be solely attributed to nursing care. Bloch (1975) suggests that some patient problems can be defined as nursing problems (she cites debucitus ulcers as an example) which respond to only nursing care (i.e. without medical prescription). However, Bloch (1975) is in fact attempting to place a patient problem within a nursing vacuum which may exclude the influence of medical care but

cannot exclude the influence of social factors, environment and family, for example. Although many nursing theorists, such as Orem (1985) have, like Bloch, attempted to define the "nursing problem" it is arguable whether "health visiting problems" can be isolated. Health visitors see their vocation in terms of client needs (Orr 1985) rather than soluable problems which respond to health visitng activities. Moreover, the needs are those of the client and cannot be separated from their social context. Thus, the problem of defining outcome criteria is magnified: can client needs be shown to be met by health visiting activity alone? Without carrying out experimental studies which isolate clients from their social context it is impossible to reach a valid conclusion. Therefore, evaluative studies of health visiting must take all other variables into account because health visiting (and nursing) is not practiced in a vacuum.

Studies of client health status

Research which has attempted to evaluate the effect of health visiting on health status has largely been carried out on an epidemiological basis,through studying patterns of infant morbidity and mortality and the incidence of specific medical events such as suddent infant death. The Jameson Committee (1956) claimed that health visiting played a major part in reducing infant mortality but was unable to offer evidence which substantiated this claim. The obvious criticism is that it is not possible to isolate health visiting inputs from other factors. The Black Report (DHSS,1980) and Whitehead's (1987) study of inequalities in health have both highlighted the major social problems such as poverty and poor housing which contribute to the health of an infant. Fluctuations in social policy affecting employment, housing and welfare benefits cannot be separated from the intervention of health visitors or other health workers, as they work within the context of policy change as described by Dingwall (1977) and Robinson (1982). Moreover, While (1985) has proposed that health visitors do not adopt a social model of health until after the first 12 months of a child's life. This suggests that during the period in which infant mortality is measured (i.e. the first 12 months of life) a biomedical approach to child health was adopted by the health visitors in While's (1985) study. Such an approach does not take account of the contextual issues of family life. This places further complexity on the issue of evaluating the effect of health visiting on infant mortality rates. Nevertheless, the infant mortality rate has repeatedly been used as an indication of the effectiveness of health visiting services. The Court Report (DHSS 1976) stated that:

> "the infant mortality rate is a sensitive indication of child health and attendant services..., it allows comparision between countries and within the same country at different times".
> (Court Report 1976, para. 2.2.7).

The Court Report based its evidence on studies carried out into sudden infant death (Carpenter and Emery 1974, McWeeney and Emery 1975, Emery 1976). This research suggested that it was possible to identify "at risk" infants and their families and that infant mortality rates could be much improved through intensive home visits by health visitors. The scoring system known as the "Sheffield Score" has been shown to be reliable in asessing risk (Carpenter 1988) but studies have not ben conclusive in the demonstration of *preventing* sudden infant death through intervention based on the score. Emery (1987) states that he was unable to find a single intervention study related to child abuse which could prove that current accepted regimes of care were effective. He suggests that similar problems exist within interventionst studies of sudden infant death and that proof of effectiveness is not complete though it is "highly suggestive". Emery (1987) also questions the ethical implications of applying intervention strategies which cannot be described as definitely effective. He implies that the imperative should be a search for methodologies in this field which will give clearer indications of effectiveness.

A further problem which arises from this kind of evaluation is the missing data on families who do not participate in the study but go on to experience sudden infant death. An earlier study by Carpenter and Emery (1977) found that 14.3% of the population who refused participation in the study and experienced a suddent infant death could not be explained in terms of health visitor intervention. Health visitors are aware of the problems that can arise in terms of risk to the child's health when clients either refuse a service or accept a service very infrequently . Often, those families who resist the preventative support of health visitors are those most at risk of health problems. There is therefore no way of knowing whether the 14.3% in Carpenter and Emery's (1977) study could have had their child's death averted by accepting the health visitor's intervention. Robinson (1982) carried out a study which attempted to evaluate health visiting among families who did not take up child health services. Robinson (1982) used three criteria to identify children who were not having access to

the child health services. These were, attendance at child health clinics, update of immunisation and attendance at paediatric development sessions.

Through a careful sequential analysis of both computerised and health records, Robinson found that of a total birth population of 2,551 only 10 infants were recorded as defaulting both the 6 week and 6 month paediatric assessment. Of these, Robinson was able to interview only four. From these four case studies Robinson argues that her thesis that health visiting practice is either relationship centered or problem centered is largely supported. This thesis is grounded in the extensively reviewed literature and "intuitive observation". Some comparative data from families who do accept services would have been an interesting dimension and would perhaps have given the thesis further support. She proposes that "successful" health visiting (in terms of uptake of child health services) is dependent on the establishment of a satisfactory relationship between health visitor and client, and that a problem orientated approach is seen as controlling and authoritarian by clients. The value of Robinson's study seems to lie more in her illumination of the complexity of identifying families who do not accept child health services than in her evaluation of health visiting interventions, since she herself admits that a direct relationship cannot be established between non-attendence for paediatric developmental assessment and health visitor intervention due to the many uncontrollable variables, such as influence of the family. It is however, one of the few studies which have examined non-acceptence of services.

While's (1985) assertion that health visitors do not adopt a social model of health until the infant's second year is based on a retrospective, evaluative survey of recorded health visiting practice among three samples of infants within a birth cohort between August and October 1980. The survey's evaluative nature can be recognised through While's attempt to relate home visiting practice to uptake of prophylactic services.

The samples were derived from three demographically different areas: an inner city area (756 infants), a suburb (127 infants) and an affluent suburb (97 infants). While supplies very ltle explanation for these wide variations in sample sizes. One could speculate that the fact that the sample from the affluent suburb is only about 12% of the sample from the inner city area that the inferences drawn by While may be questionable. Whilst home visiting was more frequent in the inner city area, While found that during the first 12 months of life health visitors relied on variables such as contact with the services and the observation register to prioritise their visiting whilst social factors such as paternal unemployment became more prominent indicators for home visiting during the second year. While suggests that this could partly be accounted for by the health visitors lack of a theoretical framework on which to practice during the first year of an infant's life coupled with an increasing recognition of social disadvantage being linked to non-uptake of prophylactic services during the second year. However, While fails to recognise the overlapping nature of a health visitors caseload and the inherent nature of practice. Health visitors, it must be assumed, do not visit each family in isolation without relating their previous experience with other families to each new encounter. The work of Schon (1983), for example, suggests that a practitioner reflects on her practice and uses her experience to learn and improve practice. In the light of Schon's work, it seems unlikely that health visitors would not learn very quickly that social disadvatage is as an important indication of child health experience as factors such as child birth and contact with hospital, and use this knowledge to adjust their home visiting patterns accordingly. Thus, While's explanation of home visiting practice seems too simplistic. This could be related to the nature of her data - both in relation to its retrospectiveness and the fact that written records were her only source. Retrospective data cannot take account of change in health visiting practice due to sickness or mobility and recorded data relies on the quality of recording of, perhaps, several health visitors for one family which will be affected by the individual health visitors' competence in record keeping, memory and even honesty. Some qualitative data in the form of interviews with a

selection of the health visitors with regard to their home visiting practice would have added a valuable dimension to While's survey. Quality of health visiting practice in relation to acceptance of prophylactic services is not apparently recognised by While as having equal validity to quality of visits. She suggests that health visitors do not have enough contact "to sustain any programme of health teaching or support". Since the health visitors activities are evaluated only in terms of uptake of services there is inadequate data on which to base this assertion. How does the author know, for example, that "support" has not been sustained through two very high quality visits? Would six visits have been any better? Is uptake of services any measure of health teaching or support? Clients have a right and choice to decline services if they wish. Only data of a complementary nature to that offered by While could begin to answer these questions. Such questions become more intriguing in the light of Robinsons (1982) argument for relationship-centered health visiting practice.

Dobby and Barnes (1987) have suggested that quantification of home visiting "provides no measure whatsoever of the effect which the service is having on health status and health potential of the community." They attempted to measure the value of routine home visiting by assessing the current needs of a random sample of 0 - 5 year olds. Each health visitor took a random sample of eight infants from her caseload and assessed the health status of the child according to a standardised form. In one district, it was found that 13.8 attempted visits per day would be necessary to maintain adequate routine surveillance, compared to 10.1 and 8.6 attempted visits per health visitors per day in the other districts. Interestingly, the district with the high rate of unsuccessful visits was also found to be higher than the other two districts on almost every index of need, which the authors suggest is an indication of the potential value of home visitng for maintaining health status. This is an interesting way of measuring the value of one aspect of the health visiting workload. The same authors (Dobby and Barnes 1987) also tried this method of evaluation with routine visiting of the elderly. However, this was not so successceful due to the extra pressure put upon health visitors

to draw randomised samples from G.Ps age-sex registers, rather than using exisitng caseloads. Also, a misjudgement in the age of the selected cohort (60-65 years) merely led to the conclusion that many elderly people in this age group are still actively working and health visitors were unsuccessful in obtaining an assessment of need. However, the authors conclude that, potentially, this could be a valuable way of demonstrating unmet need among the 0-5 years and allocating resources appropriately. A recent report by Hull (1989) reflects the current ideology for cost-effectiveness. Hull promotes the use of information technology in outcome evaluation by "scoring" families and targeting resources at those in most need according to the scores acquired. The work is not empirically based and the system takes little account of qualitative aspects of the health visitors assessment nor are the client's subjective views of their needs is accounted for.

It is evident that attempting to evaluate health visiting in terms of client health status is fraught with problems of inference. Other methods of evaluation may be more appropriate.

Alternative approaches to outcome evaluation

A variety of alternative approaches have been adopted in order to reach an assessment of the health visitor's effectiveness. These have used focussed health visiting (Lauri 1981, Luker 1982), case load review (Hunt 1982) audit of unmet need (Dobby and Barnes 1987) and client behaviour change (Macleod Clark et al 1987). Focussed health visiting uses goal attainment as the criteria for outcome. Lauri's (1981) Finnish study of the effect of public health nurses' guidance on infant health care and education took an experimental approach. Her findings suggested that focussed guidance did not increase the overall knowledge of the parents about child care although parents in the experimental group felt more able to apply their knowlege than the control group. As part of the study Lauri (1981) attempted to develop tools which can be used by the public health nurses to evaluate objectives related to child development in their day-to-day

work. Lauri does not seem to consider there to be any problems related to the fact that the public health nurses administered the tools themselves, which included variables such as mother-child relationship as observed by the public health nurse. In a study of effectivenss of intervention by the nurses it is impossible to eliminate bias from the results if the nurses are assessing their own effectiveness. However, it is recognised that subjective assessment may be useful as a practice tool. Luker (1982) also adopted an experimental approach to evaluating goal attainment amongst an elderly population visited by health visitors. Luker used Suchman's (1967) approach to the evaluation of goal setting which looks at improvement in problems rather than the attainment of behavioural goals using both subjective and objective measures. Luker found that a significant number of problems in the experimental group improved compared to the control (no intervention) group. Luker proposes that health visitors should adopt a problem orientated approach to evaluate their own practice. This contrasts with Robinson's (1982) analysis which suggests that a relationship centered approach is more effective. Both studies rely on the client's reports of their health visitors interventions and as Luker (1982) points out there is no evidence from her study of what particular skills or approaches helped the clients poblems to improve. Additionally, it could be that health visiting styles when visiting the elderly need to be different to those adopted when visiting families with young children. Elderly people may have easily identifiable problems with their health (e.g. pain, loneliness) whereas families with young children may not have problems which can be readily identified by both health visitor and client. Without direct data on the process of the interventions it is not possible to arrive at any valid conclusions on this aspect of the evaluation.

A study by Macleod Clark et al (1987) attempted to approach this problem by adopting a case study approach to the evaluation of nurse-client health education interactions. The outcome criterion in this study was the behavioural goal of changing smoking behaviour defined as either cutting down or stopping completely. The study analysed the interactions of twenty nurses and including health visitor and forty-two clients following a short training course and substantial validated changes in smoking behaviour were found amongst some of the clients. Seventeen per cent stopped smoking completely and thirty one per cent cut down. The authors suggest that this compares favourably with previous studies of smoking cessation, such as that by Russell et al (1980). The qualitative analysis of each case study in Macleod Clark et al's (1987) work suggests that positive outcomes can be related to the interactional style of the intervention. This finding is tentative, however, since it is difficult to isolate communication variables from environmental and social factors.

Hunt (1982) has suggested using caseload profiles to evaluate health visiting practice. She suggests that health visitors should define their aims, record their techniques and methods, analyse their "results' and discuss them with colleagues. Hunt (1982) is proposing that such a system of peer auditing would help make explicit the criteria health visitors use for making decisions or setting priorities. However, she offers no empirical evidence on which to base her recommendations.

It appears that no one method of evaluation of outcome has provided a reliable framework for guiding health visiting practice. Perhaps this is because, as Bloch (1975) suggests, too much emphasis is placed on outcome before we have enough knowledge of process. However, in a study of practice it is the receiver of care who can perhaps evaluate the care received most effectively. Thus, a review of the consumers evaluation of health visiting is seen as an appropriate analysis of professional practice.

The client's perceptions of health visiting

Ideally, the evaluation of any professional practice should address itself to those who are receiving and allegedly benefitting from the service. Health visiting and the child health services are largely carried out in a "private" capacity as pointed out by Mayall and Foster (1988), and the views of the clientele have rarely been sought. Thus, little is known about what actually occurs between a health visitor and her client and what the client's views are in terms of effeciveness of the service. Accountability is an important aspect of any professional practice, but it is not always clear to whom health visitors should be accountable. It could be argued that health visitors should be accountable to their clients first and foremost since clients have the right and choice to refuse services which they don't find effective for their needs. The remainder of this chapter will review the literature available on client perceptions and satisfaction with health visiting.

Graham's (1979) study of women's views of the child health service was one of the first to address this issue. She found that 70% of mothers up until one month of the baby's life and 56% after five months were positive about the child health services and the health visitor. She found that the functions attributed to the health visitor included checking on weight, advising on problems and enhancing social life and that health visitors performed these functions satisfactorly. Graham does not comment on the perception of role of the health visitor that the positive commentators had. In the case of the negative commentators (44% after five months) Graham attributes this to a negative perception of the health visitor's role - as an inspecting or policing role. Another factor which appeared to be important in the rejection of child health services was a previous experience in the clinic, for example, which had caused humiliation to the mother or made her feel inadequate. Graham's survey is unable to reveal the further factors which may be associated with a rejection of the health visiting service such as the idividual communication skills used by the health visitor or what other psychosocial factors were operating in the mother's situation. However, it is a valuable

contribution to the study of health visiting since it was one of the first studies to question the structure and organisation of the child health services from the client's point of view.

In a similar study Field et al (1982) interviewed women about their views on the health visiting service and also found 60% of the sample (78) were positive but again no clear suggestions are made about the role perception of the positive commentators. Among the 40% who made negative comments, similar factors to Graham's findings were found such as authoritarianism, a perceived interferring attitude and lack of sympathy. Additional findings were that childless health visitors were not seen as useful and the enquiry also found that there was an inability among health visitors to identify post-natal depression. In this study 40% of the mothers felt depressed and of the 18% who were truly depressed, none consulted the health visitor. This again suggests a lack of understanding of the health visitor's role and is supported by Hennessey's (1986) work on post-natal depression in which 47% of the study sample (n = 235) were considered to be at risk of post-natal depression by the researcher and only 11% were identified as such by the health visitors.

A study by Moss et al (1986) of mother's at 6 months post-partum found, like Graham (1979), that social class becomes an important factor in attitudes to services at around the six month period when clients of social class four and five become increasingly dissatisfied with health visitors. They speculate that this could be due to the social distance which often exists between the health visitor and the working class client and also because working class women had a wider kinship network in the vicinity than the middle class women and the help of relatives was valued more than that of the health visitor.

Orr's study (1980) of working class women in Ulster also highlights the clients' pereceptions of the need for health visitors in the early months of motherhood. This retrospective survey of 68 women found that health visitors were generally held in a

favourable light and that home visiting was an acceptable activity to over two thirds of the sample. However, dissatisfaction was expressed with fragmentation of services, poor clinic facilties which prevented private conversation with the health visitors, a tendency by health visitors to call unannounced and a need for health visitors to improve their interpersonal skills. Orr's study is very valuable since it has addressed the needs and perceptions of a minority group: working class Ulster women. However, it is a limited study in the sense that the survey was retrospective and thereby relied on the women's memory of their interactions. There may be a problem with validity - the women may be reflecting their mood on the day of the interview onto health visitors. It presents only the women's views, health visitors are not given an opportunity to give their side of the story and there is no material which supports the women's evidence regarding the interpersonal skills of the health visitors.

A more recent survey by Foster and Mayall (1990), however, has produced similar findings. This study looked at the views of thirty-three mothers with a first child of twenty one months on the child health services. The views of the parents in an inner city area were compared with the views of a randomised group in the suburbs of London. The study was based on a longitudinal design so that parents were interviewed three times over a period of one year to reach an understanding of their perpectives of the preventive child health services overtime. Unlike Orr (1980), the researchers in this study used open-ended, in depth interviewing and they also interviewed the health visitors involved with the families. The study suggests that from the health visitors perspective a behavioural model of education is adopted which the authors describe as authoritarian and pedagogical. This supports Sefi's (1985) work on health visitor - client interactions. Mayall and Foster (1990) found that even when health visitors rejected an authoritarian style they favoured a model of health education which assumed the health visitor was the expert and knew what kind of behaviour would be "best" for the client. In contrast, the clients in this study generally disapproved of the "top down" approach and felt that their own expertise in child care was undermined by

the health visitors introduction of topics regardless of the mother's knowledge. This again supports Sefi's (1985) findings. The mothers in Mayall and Foster's (1990) study liked the health visitors who adopted a partnership approach in their dialogue. Mayall and Foster (1990) largely explain their findings in terms of educational theory - that the education of health visitors is inadequate leading to a practitioner who is limited in her ability to create meaningful dialogue but adopts a "top down" or interventionist approach. Whilst recognizing the importance of the one-to-one interaction, Mayall and Foster go on to recommend a community action approach to health visitng as proposed by Drennan (1985). It appears that their evidence for the need for this approach comes not directly from the clients in the study but from the sociological literature (Friere 1972). Although Drennan's work was encouraging in that it suggested a new direction for health visiting, it must be acknowledged that health visitors do not yet appear to have either the philosphy or the skills appropriate for working on a one-to-one basis let alone to work effectively with groups whose needs may be complex (MacIntosh 1986, Ashley 1987).

The main indication of the studies reviewed so far is that clients welcome home visits so long as the health visitors are "friendly", non-judgemental and sensitive to the needs as the client sees them, whilst accepting that the client does have expertise in child rearing. This does not in itself present a *prima facie* case for changing the function of the health visitor into a general community worker. Two further studies have looked in more depth at the interpersonal skills exercised by health visitors as experienced by the clients. Ashley's (1987) study takes a feminist approach to explaining women's experience of health visitors and interpretation of their needs. The study focussed on the needs of 28 women, as interpreted by themselves, attending one of three women's groups. Following in depth interviewing and participant observation Ashley (1987) found that, like previous researchers such as Orr (1980), women perceive their health visitor in a friendly light but misconceived her role as far as their own problems were concerned. The women in Ashley's study were more likely to understand the health

visitors' function in terms of child care than in terms of their own health, especially their mental health. Ashley suggests that this reluctance to discuss emotional problems with the health visitor is largely because the health vistor portrays herself as a professional who is only interested in child care and mothering. The women in this study had rejected mother and toddler groups because they felt that the inadequacies they were experiencing would be on public display in such a group. However, they did find support in the self-help groups. Ashley infers that health visitors are not recognising the need among women for meeting their needs through a community action model. However, the fact that these women were attending self-help groups implies that they were a particularly self-motivated sample. Like other researchers (Foster & Mayall 1990), Ashley also suggests that health visitors should approach their aims of facilitating health enhancing activities through a community model rather than the individualised developmental model. However, although Ashley found support for the "friendly" approach of some health visitors she does not address the skills that health visitors would need to acquire in order to work in the community in this way.

Foxman et al (1982) interviewed ninety-six women six weeks post-partum to find out about their response to the health visiting service. Although the majority (61%) were positive towards their health visitor, negative comments were mostly in relation to interpersonal skills and the authors conclude that

> "our findings underline the importance of communication skills which can help health visitors tailor their responses to the needs of individual mothers."

Although Foxman et al suggest further research in this area, they do not elaborate on the nature of the skills or the research they propose. A recent paper (Thomson 1988) demonstated the complexities of workng with vulnerable groups in the community. This, as yet unevaluated project, looked at health visitors working with prostitutes in AIDS prevention and highlights the high level of interpersonal skills that are required to maintain meaningful dialogue and reach an understanding of role between the

health visitor and client. One skill in particular was flexibility which health visitors in other studies have not demonstrated. For example, MacIntosh's (1986) study of interpersonal skills in health visiting revealed a very rigid approach as the clients perceived it. The findings of this study were based on six semi-structured interviews carried out among sixty working class women from the seventh month of pregnancy until the nineth month of the baby's life.

MacIntosh suggests that "the professional style of the health visitor was...central to the establishment of an effective rapport with mothers" Thus the health visitors in MacIntosh's (1986) qualitative study who used, in Robinson's (1982) terms, a relationship centered approach, were more likely to be effective in terms of client action than those adopting a problem orientated approach. However, MacIntosh (1986) is not able to qualify this judgement and like Ashley and others relies on the client's report of the health visitors style rather than direct evidence. MacIntosh (1986) also found a high degree of unmet need among his sample of 60 working class women. Mental and emotional problems amongst the women were common as was the need for practical assistance. Often these problems were interrelated. For example, a persistently crying baby led to some mothers feeling angry and isolated and they felt that somewhere to take the child occasionally would be helpful. Health visitors were not perceived as playing a helpful role in this type of problem because they were seen as being judgemental of the mother's competence and were associated with aspects of social control including the detection of child abuse and neglect. MacIntosh largely accounts for the generally negative attitudes expressed towards the health visitors by the nature of the interpersonal skills:

> "The health visitors personality , approach and interpersonal skills are of paramount importance in determining her degree of acceptabilty " (MacIntosh 1986 : 84).

However, other studies (Graham 1979, Orr 1980, Foxman 1982) have not produced such negative findings as MacIntosh and this can perhaps be explored in terms of timing. Some studies have interviewed mothers early in their experience of motherhood whilst

MacIntosh's sample were interviewed throughout pregnancy and well into the first year of life. It is recognised by MacIntosh and others that clients are more positive towards the child health services in the early weeks of parenthood. Also, MacIntosh's sample is unusual in that all the women were working class and came from a culture (Glasgow) which traditionally has strong kinship networks which suggests that the women do not feel the need for "outside" help as much as others. However, despite these anomalies MacIntosh's study is an important contribution to the understanding of the effectiveness of health visiting through the client's eyes. MacIntosh concludes by recognising the need for a egalitarian model of health visting:

> "Giving choice to the consumer, over what help to seek and when, implies a more equal and participating relationship between client and professional" (MacIntosh 1986, p. 107).

The implication of the study, like others, is that health visiting should be a responsive service not an interventionist activity.

A survey by Watson and Sim (1989) involved the exploration of mothers' and health visitors' perceptions of home visits in an inner city area. A sample of 100 health visitors and clients were interviewed following a home visit to ascertain their perceptions of the purpose of the visit. Watson and Sim found that, in general, health visitors and clients agreed on the visit contents. The trend of these findings appear to be at variance with other consumer studies. However, this difference in findings may be explained by the large sample in Watson and Sim's study who came from non-English speaking backgrounds. For example, 38% were Bengali. Not only did this necessitate the use of translators in some cases which may have distorted the findings, but culturally Bengali women are much more likely to be compliant with perceived representatives of authority. This is substantiated by Watson and Sim's finding that 100% of the Bengali women had found the visit helpful and 82% wanted more visits, compared with only 18% of other women in the study. An additional criticism of Watson and Sim's (1989) study is that a very quantitative approach was taken to the inteviews which may have led to important issues which mothers wished to discuss

being missed. Perhaps most significantly, whilst the authors draw inferences about the level of agreement between health visitor and client during a home visit they cannot substantiate this with any observational or interaction data. The current study aims to compare perecptions of visits between health visitors and clients and to substantiate the results with direct data from the intaeractions which take place.

Summary

In summary, this chapter has addressed the question of effectiveness in health visiting. Evaluation has been looked at in terms of health status of the clients, client outcomes and client satisfaction with the service. There are limitations with all the approaches. Studies of health status, (e.g. While 1985, Carpenter and Emery 1977) have not as yet used methodologies which can take account of the influences which may interact with families besides the health visiting intervention. It is difficult in practical terms and arguably unethical to isolate health visiting from all other intervening variables. Outcome studies such as Luker's (1982) experimental study of health visitor intervention among the elderly fail to take account of what skills of health visiting are appropriate for improving problems since the outcomes rely on client's reports of the interventions.

A growing area of interest is the client's subjective evaluation of the health visitng service. This has been approached through qualitative designs (Mayall and Foster 1988, Ashley 1987, MacIntosh 1986). Although to some extent these studies begin to provide explanations for the findings of the other surveys such as that of While 1985, they generally depend again on client's reports. However, these studies appear to produce consistent findings and each report high levels of internal consistency and there is little reason to doubt the validity of the clients comments. There is a high level of agreement between these studies that health visitors need to adopt a more facilitative style, to be less authoritarian and use a more egalitarian approach. Whilst emphasis is given to interpersonal skills, little attention is paid to the nature of the interaction.

There does appear to be a gap in the literature and a need to explore further the nature of the health vistor - client interaction in conjunction with collecting data from both clients and health visitors on their perceptions of an encounter.

Studying the process of health visiting with additional data from both health visitors and clients on their perceptions of an encounter would go some way towards fulfilling Bloch's (1975) criteria for evaluative research, i.e. the exploration of relationship between the process of an intervention and its outcome.

Chapter four

Client Participation in Health Care

Introduction

It is evident from the previous discussion that there is a need to further explore the concept of client participation in health visiting. The centrality of an egalitarian relationship between client and health visitor has emerged, particularly from the research adressing the consumer perspective, and this suggests that client participation should be an important aspect of such relationships.

This chapter will address the concept of participation in health from several perspectives.

Firstly, the issue of what participation means will be explored through an analysis of the literature in the field of patient participation. Secondly, the literature addressing the value of participation will be reviewed and thirdly the extent to which patients and clients desire participation will be addressed.

What is participation?

The concept of client participation has a broad range of meanings. Clayton (1988) has argued that client participation is an under developed concept and that there is little evaluation of alternative styles of participation to identify which most appropriately meets its goals. Clayton (1988)has categorised client participation into three main domains - enhancement of decision making, enrichment of quality of life and expropriation of client's power. The research available on participation seems to accurately reflect these three areas.

Participation can be seen to encompass sick individuals' increased compliance with their treatment (Roter 1977, Ross 1987), involvement in decision making related to treatment plans (Schulman 1979, Brody 1980, Coulton et al 1982, Slimmer and Brown 1985, Valanis and Rumpler 1985), increasing patient satisfaction through negotiation

(Roter 1977 , Eisenthal and Lazare 1976, Eisenthal et al 1983, Willer and Miller 1976, Greenfield et al 1985, Littlefield and Adams 1987) and increasing self-care or self-help among patients (Drennan 1985, Brownlea et al 1984). Brownlea (1987) has suggested that participation means :

> "getting involved or being allowed to become involved in a decision making process or the delivery of a service or the evaluation of a service, or even simply to become one of a number of people consulted on an issue or matter" (Brownlea 1987: 605)

However, Brownlea's sympathies lie very much with the community approach to participation, whereas other authors have paid more attention to an individualist concept of participation.

Greenfield et al (1985), for example, argue that they have moved away from the concept of patient participation as meaning compliance with medical regimes towards a more interactional approach. These authors see the doctor-patient interaction as having most potential for patients having some influence on medical decisions and treatments. Greenfield et al (1985) operationalised this definition in an experimental study of the effect of patient participation in the interaction on outcomes such as patient knowledge, patient satisfaction and preference for involvement in decision making. Significant differences between experimental and control groups were found on the preference for decision making and knowledge dimensions. Identification of these outcomes followed taped interactions between doctors and patients where those patients in the experimental group (n=22) had been assisted by a researcher to identify questions and issues relating to gastric ulceration immediately prior to their encounter with the doctor. Those in the control group (n=22) had received no assistance in this way. Analysis of the taped interactions revealed that the experimental group were more in control of the interaction in terms of number of patient utterances per minute and more able to direct the flow of the conversation. Whilst this study has interesting implications for the current study, limitations appear to lie within the definition as the empirical work concentrates on "priming" the patient prior to an interaction rather than training the doctor to elicit patient participation. The study is

further limited by its very quantitative approach to participation. The number of controlling utterances by the patient gives very little indication of the quality of these utterances and how the physician responded to them.

For Schulman (1979), an active patient orientation is characterised by attitudes and expectations which support and facilitate patient participation, including participation in decision making. According to Schulman (1979), this approach requires the physician to provide the patient with the information needed to make informed decisions, to actively solicit patient input and preferences in the formulation of treatment plans and goals, to provide the patient with the resources necessary for the implementation of the treatment plan and to reinforce patient participation. Schulman tested the validity of this approach in an experimental study of hypertensive patients who had been randomly assigned to one of three treatment groups - routine clinic care, routine care with additional patient education and routine care, patient education and contingency contracting i.e. a negotiated agreement. Outcome measures included control of blood pressure, medication side effects and adoption of health promoting activities. Schulman suggests that through the measurement of these outcomes using the "active patient orientation questionnaire" that the three treatment formats afford varying degrees of patient participation, with the contingency contracting group making the most significant impact. However, again Schulman's study appears to rely on educating the patient rather than exploring the attitudes and approaches of the professionals. It is also limited by lack of direct data about the doctor-patient interaction and the fact that some of her interviews and follow-up took place two years after the original study. This suggests that the patients were already highly commited to their treatment and has implications for the reliability of her data.

The focus of the current study is on client participation in health visiting. Whilst recognising the valuable work which is being done by health visitors in the area of

community development and self-help, this study concentrates on participation at the individual level, specifically on the health visitor/client interaction. Brownlea's (1987) approach was therefore rejected as health visiting practice has not yet moved wholly towards a community model.

As Greenfield et al (1985) suggest, the health visitor/client interaction was perceived to be the point at which parents currently have the greatest opportunity for participation. However, Greenfield et al's (1985) approach to participation was rejected on the grounds that it concentrates too much on medical outcomes and is limited by its lack of involvement on the physician's part.

From this perspective, Schulman's (1979) approach seemed promising but again was seen to be inadequate through its concentration on medical outcomes. Therefore , for the purposes of the current study, an operational definition of participation was selected from the health education literature. D'Onofrio (1980) suggests that client participation is client involvement in:

> "Problem identification and prioritisation, establishment of change objectives and the process of making decisions about how change will be accomplished." (D'Onofrio 1980:274)

This definition was seen to cover the major aspects of the professional/client relationship in terms of health promotion. Health promotion is perceived to be a major component of health visiting practice (CETHV, 1977). Therefore, it seems reasonable on a one-to-one level that clients should be involved in deciding what their health needs are, what changes they need to make and how that change will be achieved. It also allows for analysis of participation within the interaction between health visitors and clients.

The value of participation in health

The concept of participation as "desirable" can be seen to have originated from several sources. The earliest and most frequently cited in terms of modern medical health care is the model of medicine proposed by Szasz and Hollender (1956). The model describes

three types of physician/patient relationships in terms of decision behaviour: Activity - Passivity, Guidance - Co-operation and Mutual Participation.

In the Activity - Passivity relationship the patient is completely helpless and passive and the physician does something to him and this model is seen as appropriate for emergencies. The second type applies to acute disorders and especially to those of an infectious type. The patient can exercise judgement but he is expected to look up to his physician and obey him, thus fulfilling the Parsonian (1951) sick role. The third type, mutual participation, is presented as appropriate for the management of chronic illness, in which the treatment programme is carried out by the patient with only occasional physician consultation. The physician helps the patient to help himself. The Szasz and Hollender (1956) model is prescriptive, indicating how they believe doctors and patients ought to behave in certain situations. There is no exploration of patient preferences and no allowance made for a relationship outside the traditional Parsonian (1951) model of sickness. Health promotion was clearly not recognised as a physician's function in 1956. Nevertheless, the model has been adopted as a framework for studying patient participation (Vertinsky et al 1974, Brody 1980) and it is generally recognised as "desirable" for health professionals to move towards mutual participation. A second influence on the growth of the concept of participation is from within primary health care, more specficially, arising from the declaration of Alma Ata (WHO, 1978). The well quoted Declaration sets out themes and goals around which nations should develop and work towards Health for All by the year 2000 through the principles of primary health care. Paragraph IV states:

> "The people have the right an duty to participate individually and collectively in the planning and implementation of their health care" (WHO, 1978)

Primary Health Care is seen as:

> "essentially health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individualsand families in the community through their full participation..." (WHO 1978, para VI)

It is also suggested that Primary Health Care...

> "requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care..." (WHO , 1978, para vii)

Essentially, the WHO see participation operating at three levels - individual, family and community. Whilst it is unclear precisely how the WHO define participation it can be seen to include aspects of planning and decision making at both individual and community levels and also encapsulates concepts such as self-help and self-empowerment.

It is within this context that health professionals working in the fields of primary health care and health promotion have come to recognise participation as desirable and appropriate as demonstrated, for example, by the recent HVA document "Bridging the Gap" (HVA, 1988).

A third influence on the growth of participation in care as a valued concept can be recognised as stemming from the people who use the health services. This movement is often referred to as "consumerism" (McEwen et al 1983). Ideologically, the concept of health as an item which can be bought and sold and bartered for in the marketplace in the same way that other consumer items are, suggests that the term may be unacceptable by those who believe that health is the right of an individual or community (as recognised by WHO, 1978). What is termed "consumerism" can be simply seen as the exercising by the people of their right to access to health care on their own terms. However, an alternative, monetarist ideology, would view the health professional as a producer of health providing a range of products in which consumer choice is recognised as participation and profit is the motivating force (Graham 1985). Such an ideology is inherent in recent UK government strategies proposed for reviewing the National Health Service (Department of Health, 1990). This approach leaves in abeyance the question of who will actually have a choice in their health care and clearly the potential for yet greater inequalities in health care exists. Whichever ideology is adopted, participation at this level can be understood in terms of

> "initiative coming from the people in order to increase their autonomy either in terms of power or choice"
> (McKewan et al 1983)

Despite the conflict between ideologies, the term consumerism has been applied across the board to describe the phenomenon which Mckewen et al (1983) suggest has its roots in the women's movement, the civil rights movement, welfare rights movement and the anti-war movement. This has had most impact at group and community level where there is a wide range of organisations utilising a variety of approaches to achieve their ends. Such organisations are generally categorised as "self-help" groups, self help meaning that a group with collective values have worked together outside the traditional official boundaries to reach a common goal.

Having looked at the growing enthusiasm for participation it is important to review and critically evaluate the research which has addressed the value of participation; i.e. to what extent is participation "desriable" when put to the test? The studies covering this area are as diverse as the definitions of participation and are thus categorised according to the level of participation in operation.

Participation at the individual level

The value of participation at the individual level has been explored by many researchers, largely in the study of the doctor-patient relationship. The effect of participation on outcomes such as compliance, patient satisfaction and decision making have all been observed (Roter 1977, Shulman 1979, Eisenthal et al 1983, Tucket et al 1982, Greenfield et al 1985). The emphasis of such studies is that patients or clients should be active protagonists in their health care and not passive recipients i.e. that the 'Activity-Passivity' phase of Szasz and Hollender's (1956) model is inadequate and that the move should be towards mutual participation in care. The literature suggests that this is largely to be achieved through modification of the doctor-patient interaction. Many of the theoretical assumptions of these studies can be seen to be drawn from Kleinman's (1975) anthropological framework of cultural explanatory models. Kleinman has proposed that professional and lay frameworks of knowledge in relation to health and illness are different. The way in which a lay person explains his health behaviour will be different to the health professionals' explanation because of cultural variations; this does not make it wrong. Thus, Kleinman has proposed that the traditional biomedical model is an inadequate guide for patient care as it fails to take account of differing cultural values and explanatory models of illness, health and behaviour between the health professional and the patient. Kleinman subscribes to a negotiated approach to the doctor-patient relationship in which the patient's explanatory model is elicited by the health professional through sensitive interpersonal communication in which empathy is seen as a key concept (Katon and Kleinman 1980). A satisfactory therapeutic outcome for both health professional and

client is seen to be dependent on the unification of the professional and lay explanatory models. Such a theoretical framework would appear to be relevant to health visiting.

Roter (1977) has approached participation in the doctor-patient relationship through the assumption that increased patient question-asking will ensure that the professional's explanatory model will be made more clear to the patient who will therefore be more satisfied with his care and more likely to comply with therapeutic advice:

> "Because questions are the most usual indication of patient activity in the interaction, physicians may take the expression of a question as an indication of patient desire for greater participation. As a result, these patients would receive more detailed explanations of their illness, thereby entering into a communication process."
> (Roter 1977:287)

Roter proposes a concept model representing the factors which contribute to increasing patient question-asking. This is based on Green's (1976) educational diagnosis of a health educational problem in which recognition of enabling factors (e.g. patient's ability to articulate questions) predisposing factors (e.g. the patient's belief in the acceptability of asking questions) and reinforcing factors (e.g. positive responses to questions) are seen as having a positive effect on the behavioural problem, in this case question asking by patients. Roter took an experimental approach to testing the hypothesis that a health education intervention with patients prior to a medical consultation which incorporated this model would increase patient question asking and indirectly increase patient satisfaction and compliance in terms of appointment keeping.

Participants were assigned to the experimental group in which a health educator worked with the patient through a question-asking protocol to identify questions the patient may have concerning his illness or treatment or to a placebo group in which patients spent the same amount of time with a health educator discussing the use of the emergency room. There was also a non-randomised control group. Following the

intervention, data were collected by means of audio-taping the doctor-patient interaction. This was followed by a 15 minute interview with the patient related to satisfaction and health locus of control variables. Appointment keeping was also used as an outcome measure and monitored by inspecting records both retrospectively and prospectively. The results indicated that those in the experimental group did significantly increase their question-asking. However, contrary to the hypothesis, this seemed to cause dissatisfaction among the experimental patients although appointment keeping was significantly increased. Roter explains these findings in terms of dissonance. She proposes that since neither doctors nor patients are used to an active patient role the experimental information could have given rise to anger, anxiety and dissatisfaction. This gives rise to dissonance which is a motivating force in itself for behavioural change such as appointment keeping. In her conclusions, Roter suggests that "anger and anxiety may be instrumenal to patient behaviour change" (Roter 1977:304)

Roter's study can be criticised on several points. The first is her assumption that becoming an active patient is the patient's responsibility in that he should ask more questions. An alternative view which would be compatible with Kleinman's (1975) exlanatory model theory would put the responsibility on the health professional to elicit the patient's participation. In Roter's (1977) study there is no information about the physician's role in the study - was he aware of the research aims? How did he react to patient questions? Were other cues of patient activity responded to? It is possible that in a relationship where the patient was expected to ask questions where this was not traditionally the case, that the patient would become anxious through the knowledge that he carried this responsibility. A study where the physician is trained to elicit the patient's questions might yield different findings.

Secondly, the outcome criteria are not entirely adequate. Although satisfaction has been used as an outcome measure in other studies (Eisenthal and Lazare 1976, Willer

and Miller 1976, Eisenthal et al 1983, Greenfield et al 1985). Speedling and Rose (1985) suggest that the meaning of satisfaction to patients may affect health related outcomes. It is suggested that patients derive satisfaction from a warm, caring relationship (Ware et al 1978, DiMatteo et al 1979) and that this may be unrelated to the physician's therapeutic expertise. Speedling and Rose (1985) propose that "being cared for by a supportive professional may foster complacency and dependancy rather than autonomy..." (Speedling and Rose 1985:117)

As such, the authors conclude that satisfaction is a poor indicator of the quality of the doctor-patient relationship since a therapeutic relationship must be shown to be effective as well as 'friendly'. A review by Fitzpatrick and Hopkins (1983) also cautions against the injudicious use of satisfaction as an outcome measure as it provides only partial insights into the perspectives of the patients studied. Roter's (1977) only criteria of effectiveness is appointment keeping which is inadequate in therapeutic terms since other variables may intervene. Indeed, Roter observed a seasonal variation in appointment keeping behaviour. Despite the fact that Roter's sample were all chronically sick there is no indication of outcome in terms of treatment. Moreover, the question of whether patient question asking constitutes participation is at issue. Question-asking by the patient can perhaps be seen as one aspect of participation but other authors have suggested a more comprehensive view of patient activation. D'Onofrio(1980) for example, has suggested that participation in a health education process would include

> "active patient participation in problem identification and prioritization, in the establishment of change objectives and in the process of making decisions about how change will be accomplished" (D'Onofrio 1980: 274).

This clearly involves much more than simply asking questions. Similarly, Greenfield et al (1985) defined participation with wider parameters:

> "Within the context of the physician-patient interaction because it is there that patients can have greatest impact on medical decisions and the course of treatment"
> (Greenfield et al1985: 520).

In summary, Roter's (1977) study was limited in the conclusions that could be drawn about the effectiveness of participation since the parameter's of participation were narrowly confined to patient question asking, the physician's role in eliciting the patient's explanatory model was unclear and the outcome criteria were inadequate.

Other studies have approached the problem from a different perspective. Greenfield et al (1985) followed a similar protocol to Roter (1977) in that the study design involved "training", of patients to become more active followed by an experimental analysis of the effects of the training on outcome. The design also incorporated a "before and after" measure. However, as previously noted, participation was more broadly defined to include decision making. To this extent, other interactive measures of participation besides patient question asking included the number of controlling utterances by patients, ratio of patient to physician utterances, ratio of physician's information conveying statements to patients controlling utterance. As such the analysis of audio taped interactions produced a broader range of codes which included the physician's responses although it did not include the physician's elicitation of client participation. Greenfield et al (1985) also included a wider range of outcome criteria than those employed by Roter (1977) which included general health status, pain, preference for active involvement in medical decision making, knowledge of disease and satisfaction. The results of the study showed that the experimental group of patients were significantly more likely to be active in the interaction in terms of number of utterances and number of controlling influences, elicitation of factual statements from the physician and the ratio of patient to physician utterance. Question asking by the experimental group was not significantly greater. Moreover, these measures of participation correlated significantly wth some aspects of the outcome criteria, for example effectiveness with information seeking was associated with fewer role limitations for patients in the experimental group. However, satisfaction was not

significantly different in the experimental group and knowledge of the disease was significantly higher in the control group.

The authors suggest that attempts to control the conversation flow, other than by question asking, may be more effective in eliciting information from the physician. For example, it is suggested that question asking may be too threatening for patients and that more subtle techniques such as joking or attributing uncertainties to others are employed. Whilst the authors recognise the importance of the health professioanal developing an awareness of these subtle strategies there is no indication from the study of the extent to which physicians are able to do this. It is possible that a highly skilled health professional would acknowledge more of these cues and enhance health outcomes further. A further limitation of the study is again related to therapeutic outcome which was not measured. Measures of health status were carried out using self-reporting scales which, whilst being claimed to be valid by the authors, do not give the same objective measures of changes in therapeutic activity as perhaps some physiological measures would. Thus, the validity of the study could have been enhanced by using a different patient group such as those with hypertension where observable changes could have been identified. Greenfield et al (1985) conclude that increasing patient involvement in care does lead to improved health outcomes but acknowledge the need for further evaluative research.

Work by Willer and Miller (1976) also examined client involvement in goal setting and measured outcome in terms of goal attainment. In this study, interviews between the patient and the therapist were not audio recorded so that measurement of involvement in goal setting depended on the therapists and patient's reports. Therapists were encouraged to involve clients in goal setting although only 15 of the group (N=72) actually reported setting their own goals. The authors' findings, which suggested that involvement in goal setting was related to attainment of goals and patient satisfaction, was therefore based on these 15. Since there was no control group or baseline data, the

validity of these findings is questionable. The study does, however, put some of the onus on the therapist to elicit patient goals but some indication of the nature of the interaction would have strengthened the findings of this study.

Studies reported by Eisenthal and associates (Eisenthal and Lazare 1976, Eisenthal et al 1983) have looked more closely at the role of the health professional in eliciting patient requests and negotiating a treatment plan, an approach the authors refer to as a "customer approach", putting health care within a consumer orientated framework.

The authors claim that:

> "Open ended negotiation between the clinician and the patient is seen as essential for productive planning, decison making and treatment dispositon." (Eisenthal and Lazare, 1976; 169)

and that

> "From our perspective, it is the clinician's task to elicit the customer's (patient's) request, gather other clinical data, and then enter into negotiation with the patient over the request and the overall treatment plan" (Eisenthal and Lazare, 1976;170)

The study involved patient evaluation of an initial psychiatric interview in terms of their perception of the consumer approach and perception of outcomes. These perceptions were measured using three Likert-type scales each consisting of between two and five items. The outcome scale was reduced from four to three items and measured satisfaction/help received, symptom relief and plan wanted. The outcome scale was very limited in scope and no comment is made by the authors on it's construct validity. Eisenthal and Lazare (1976) claim that their hypothesis that patient's ratings of the customer approach would be correlated with ratings of outcome was supported. The most strongly associated item was the clinician helping the patient to put his request into words. This was more highly correlated with satisfaction than with symptom relief or arriving at the patient's desired plan. This finding raises two issues. Firstly, the study relies on the patient's subjective perception of the customer approach. There is no independent analysis of the customer approach through tape recording of

interviews etc. The authors acknowledge that the therapists, nurses and doctors in the study had different levels of skill in the customer approach and therefore reliance on the patient's perception does not give the true picture of the extent to which health professionals were actually eliciting their patient's request. To some extent it is irrelevant how the approach is used as long as the patient feels that his requests have been acknowledged and he feels satisfied with his care. But this gives rise to the second issue which is again concerned with satisfaction as an outcome measure. This study clearly demonstrates, as Speedling and Rose (1985) have suggested, that satisfaction is a spurious criterion for outcome as it does not seem to be related to either symptom relief or the patient's desired treatment plan. This argument supports the earlier suggestions that if a patient is satisfied with the health professional's approach they may become complacent about therapeutic changes. Nevertheless, the authors conclude that patient's value the active, helping and collaborative features of the customer approach and this should not be dismissed.

A later study by Eisenthal and associates(1983) continued to use satisfaction as the outcome criteria but this was expanded to include the clinician's perception of patient satisfaction and the clinicians own satisfaction. In addition the psychiatric interviews were audiotaped so that measures of participation (mutuality in making the treatment decision and mutality in communicating exploratory information) were based on observable data rather than relying on patient perception.

The study found that negotiation variables correlated significantly with patient, but not clinician, satisfaction. Furthermore, it was found that the clinician's perception of patient satisfaction differed consistently from the patients own perceived source of satisfaction. The study carries all the aforementioned problems of using satisfaction as an outcome measure. However, it also has implications for practitioners in terms of what Eisenthal et al (1983) refer to as mutuality of power. The findings suggest that clinicians expect patients to be satisfied only if the recommended treatment coincides with the patient's request, whereas patients feel more dissatisfied if the clinician does

not engage in pursuing a consensus, thereby sharing ideas and information and, implicity power. Eisenthal et al's (1983) study suggests that there is a divergence between the clinician's and patient's value system concerning the initial interview process and that this can give rise to strain and failure to adhere to plans for treatment. This would support Kleinman's (1975) theory of explanatory models. The authors suggest that further research should be carried out about the factors influencing the clinician's use of the negotiated approach.

In summary, the review so far has looked at research surrounding participation in the healh professional-patient interaction both in terms of "training" the patient to become more active and the practitioner's role in eliciting the patient's desires. Most studies discussed have used an experimental approach to evaluating the effect of participation and patient satisfaction has frequently been used as an outcome measure. It is proposed that satisfaction is not always adequate as an outcome criterion (Speedling and Rose 1985, Fitzpatrick 1983) since the patient's satisfaction with an empathetic approach may bear little relationship to actual therapeutic effect. The following section of the review will evaluate more closely studies which have examined the process of participation in decison making.

Participative Decision Making in Health Care

Decision making in health care is fraught with problems of power and control. Professional practitioners see decision making as part of professional autonomy (Friedson, 1970). This conflicts with the notion of the patient as an expert who can contribute to the decision making process (Tuckett et al, 1985). It is difficult for professionals to share their knowledge on an equitable basis with patients and to accept that patients have knowledge and experience which could enhance the decision outcome. Slack (1977) put forward the case for physicians being active in enabling their patients to reach their own health care decisions. Slack argues from a clinical standpoint that a well informed patient should be able to make her own health related decision if she desires without the physician being at risk of liability as he is from the paternalistic perspective of practice. It is this ethical aspect of patients making their own decisions which has worried doctors and nurses. Who will be accountable if anything goes wrong? Trandel-Korenchuk (1982) has approached this problem from the perspective of the Patient's Bill of Rights which exists in the United States. Although no such document exists in the British system, the ethical principles are pertinent to health care in the U.K. The Patient's Bill of Rights is primarily concerned with the right to self-determination and informed consent both of which areas require participation in decision making on the part of the patient. Trandel-Korenchuk uses Szasz and Hollender's (1956) model of the doctor-patient relationship in order to illuminate the ethical considerations. She proposes that the active-passive model is only ethically acceptable in life-threatening emergencies. In the guidance - co-operation model, which, according to Stone (1979), is the most prominent model in medical practice, a token gesture is paid to client participation in decision making. However, it is suggested by Trandel-Korenchuk (1982) that it is within the mutual participation model that the client may freely participate in decision making and where informed consent can be validly and effectively obtained. Fenner (1985) has also argued that in reaching informed consent the patient must participate in clinical decision making and take some responsibility for the consequences.

Brody (1980) also used the Szasz and Hollender (1956) model as a framework for promoting participative decision making. Brody proposes four steps in the clinical approach which could enhance mutual participation. The first suggested step is the establishment of a conducive atmosphere in order to make patients feel both independent and valued. Open questions and early response to patient questions are advocated. The second step is theoretically based in Kleinman's (1975) work on explanatory models and proposes that the patients goals and expectations should be elicited. The third step involves educating the patient about the nature of the problem, discussing pro's and cons, explaining the physicians preference. The last step involves eliciting the patient's informed suggestions and preferences and negotiating disagreements. Whilst proposing some potential benefits of this practical approach to care Brody (1980) recognises the hypothetical nature of these advantages to both physician and patient and the need for empirical validation.

Kim (1985) has proposed a theoretical framework for participative decision making between nurses and patients which takes three theoretical perspective into account. These are the sick role theory conceptualised by Parsons (1951), the assymetrical power relationship between doctors and patients as defined by possession of knowledge and expertise and the effects of participation on the individual in terms of satisfaction, decreased feelings of powerlessness etc. Whilst all three perspectives have been acknowledged in other studies, Kim's work appears to be the first to bring the areas together in a theoretical construct. The theoretical model proposed by Kim is in the process of being tested in relation to participative decision making and pain control (Kim, personal correspondence). Kim suggests that four main independent and interdependent variables will influence the clients participation in nursing care decision making these being the client, nurses, organisation and decision type. The relationships between these variabes form the basis of future research proposed by Kim (1985) which includes a need for:

> "Descriptive knowledge about current practice in collaborative decision making in nursing practice " (Kim 1985: 287).

The general lack of nursing research in the field of client participation would suggest that this need for descriptive evidence is paramount.

There is some empirical evidence that participative decision making in health care is a valid construct. Tuckettet al (1982) carried out a study of the integration of lay and medical frameworks of knowledge through informed decision making. Unlike previously covered research (Roter 1977, Shulman 1979, Greenfield 1985) Tuckettet al trained the General Practitioners in the research to elicit their patient's framework of medical knowlege in order to enhace informed decision making. Consultation between GP's and patients were audio recorded and patients were subsequently interviewed. Tuckettet al's (1982) study considered that the interactive nature of the ordinary GP consultation provided a special opportunity for health education, which would take into account the existing (lay) framework of knowledge through which individuals interpret and evaluate the information they recieve from the source of health education. The study is worthy of review in some depth since it contributes considerably methodologically to the understanding of the lay participation paradigm. The view which accepts the idea of the lay framework of knowledge has been agreed by medical anthopologists and sociologists such as Katon and Kleinman (1980) and Calnan (1987) and advocates of the Health Belief Model such as Becker and Maiman (1975). Katon and Kleinman's (1980) approach involves the elicitation of the patient's explanatory model of his illness by the physician. The explanatory model contains the patient's understanding of the cause of his illness, it's pathophysiology, expected course and prognosis and the treatment that be believes will or should be administered. Katon and Kleinman argue that in order to elicit this explanatory model the health professional must use open ended questions and questions which do not contaminate the patient's perspective with the physician's assumptions:

> "In order to elicit such information the physician must demonstrate warmth, empathy and persistence; and he must be non judgemental" (Katon and Kleinman 1980: 259)

Thus, against this theoretical background Tuckettet al(1982) aimed to explore the potential for informed decision making in which lay and professional frameworks of knowledge are integrated.

Three main issues were addressed in this study and these were explanation to patients and how it is given, patient understanding of received information and the process by which it is achieved and the part played by patients in the consultation and the extent to which they could influence them.
The study therefore aimed, in relation to these issues, to provide descriptive data, explore methods of assessing explanation, patient understanding and patient participation and to answer questions about the feasibilty and effectiveness of consultation approaches based on implementing ideas, about informed participation and the integration of lay and professional frameworks.

To fulfill these aims the authors studied 405 ordinary general practice consultations, although they do not make it clear what criteria constitute "ordinary". What is ordinary in a London suburb practice might be quite extra ordinary in a semi-rural or inner city practice. Criteria for exclusion included people under 18, those not speaking English those attending for repeat perscriptions or coughs, colds or contraception. This leaves little scope for what might be considered "ordinary." Of the 405, 328 patients were later interviewed in depth at home.

The authors describe an elaborate methodology for measuring doctor explanation, patient understanding and patient participation such as had not previously existed in the literature. The rating scales were designed to measure several dimensions of each apsect of the interaction. This enabled the authors to move away from the classic

communication model as described by Ley and Spelman (1967) in which effectiveness of information giving, for example, is measured by patient recall alone. Tucket et al (1982) looked at doctor explanation in terms of the significance of the problem, the action recommended, prevention of further occurance and the implications of the problem.

Each of these topics were analysed according to content (i.e. what the doctor said) and justification (why he said it). It was also analysed according to the doctor's style and his techniques of information giving. Style involved the extent to which the doctor attempted to elicit and integrate the patient's framework of knowledge whilst technique was concerned with the comprehensibilty of the doctor's explanation and extent to which he checked the patient's understanding. Thus, a very full picture of explanation/information giving emerged which could then be compared with patient understanding of the consultation which was measured through the analysis of semi-structured interviews. These interviews elicited patient understanding in three dimensions - recall, interpretation and commitment to the decision. The authors report high levels of reliability (>0.75 in most cases) for the scales developed in this study.

The authors found that the level of justification in the doctor explanation was less than adequate in that they were not providing enough information on which to base an informed decision. Only 10% of the consultations were reactive to the patient's own ideas and explanations and in only 8% was there more than a passive attempt to elicit the patient's framework or thinking. Not surprisingly, the authors found that despite a reasonably high level of congruence between patients and doctors on the nature of the information, it was those patients who most needed information who could not recall or misinterpreted the doctor's explanation. It also became clear that patients frequently have to "fill-in" information and make sense of minimal explanations,

often arriving at an interpretation of the doctor's decision using health knowledge and theories akin to the doctor's own. Thus, the authors suggest:

> "Our material suggests a model of learning which sees the patient as an active participant in the communication process, actively making sense and 'filling in' on what the doctor has said, and which therefore stresses the importance of the knowlege and ideas that the patient brings to be consultation for its eventual outcome." (Tuckett et al 1982: 57)

It was when patient's drew on inadequate or inappropriate health knowledge to make sense of or fill in on doctors explanations that they interpreted the doctor's decision incorrectly. This was most likely to be the fate of patients with minimal educational qualifications, a volatile or ambiguous consultation or those with a chronic condition for which the lay health knowlege was inadequate.

A further major finding was that prevention of further occurance was mininally discussed and implications of a problem hardly at all by the doctors but that some patients were able to use their own frameworks of knowledge to make an interpretation of prevention.

Again, unlike previous studies which have taken a narrow view of patient participation measures (Roter 1977, Eisenthal and Lazare 1976) Tuckett and et al (1982) attempted to measure the patient's involvement in the consultation along six dimensions, which were: presentation of the problem, elaboration of effect of the problem on their feelings and plans , extent to which the patient expressed his own ideas, sought clarification, asked the doctor for rationales and expressed doubts.

Again, the authors report highly reliable scales were developed to measure these dimensions and the methodological complexities of distinguishing different levels for these dimensions are acknowledged and the authors' definitions and criteria presented. The results of this aspect of the study indicated that for over half the patients there was no more than minimal participation. Where there was 'overt'

participation the task patients were most likely to be involved in was "seeking instruction " (47%) and the least likely task was "requesting justification" (14%). The authors found that expressing doubt and requesting justification was more likely to create an atmosphere of conflict within the consultation, much as Roter (1977) found in relation to question-asking. Thus, this was seen as a potential barrier to patients being more active in the consultations.

In summary, the authors conclude that:

> "At present, consultations are not enabling patients to make informed decisions about their health care, and are not being conducted to use this interactive potential"
> (Tuckett et al 1982:11)

This has obvious implications for both health education and further research, for as the authors

suggest:

> "...patient's beliefs are a potentially rich resource for achieving much higher levels of understanding of health issues, including the need for prevention and anticipating care, provided they are seriously explored and practitioners are prepared carefully to respond to them and work with them" (Tuckett et al 1982:123).

This study has been described in some detail because of the way in which it highlights both the inadequacy of some previous research in patient participation and communication (Ley 1976, Bain 1977, Roter 1977) and also its detailed treatment of the methodological complexities related to measuring patient participation. As well as challenging concepts traditionally held dear to medicine such as information giving, the study also challenges the value of opportunistic health education on the grounds that it could cause anxiety if not practiced within the patient's frame of knowledge. As Tuckett (1982) points out, previous studies have been rather simplisitic and pragmatic in approach and whilst acknowledging their own methodological difficulties the authors of this study have attempted to over come the simplisitic approach. This is regarded by the current writer as both a caution and an example. Whilst direct replication of the study to health visiting is not seen as appropriate, there are obvious similarities in terms of analysis which ought to be both acknowledged and addressed. These will be discussed further in chapter five .

Do patients/clients want to participate in health care encounters?

The work reviewed to this point has made certain assumptions about the desirability of patient participation. Despite some concerns about its value, these have largely been attributed to methodological inefficiencies and the assumption has been made that it is, indeed, desirable and that patient care in terms of therapeutic outcomes will improve if patients are more active, and furthermore that this is what patients and clients want. But what is the evidence that patients and clients do, in fact, desire a more active role in encounters with health professionals?

This issue has been addressed both in terms of problems of measurement (Vertinsky et al 1974, Wallston and Wallston1984, Krantz et al 1980) and in terms of what patients do or say in practice (Kim 1981, Strull et al 1984, Perkins 1983). In order to assess the extent to which clients wish to be more active in their decision making Vertinsky (1974) et al challenged Szasz and Hollender's (1956) model of the doctor-patient relationship on the grounds that it prescribes how doctors and patients ought to behave rather than addressing patient's actual desires.

Vertinsky and colleagues (1974) attempted to measure patient desire to participate by administering a questionnaire to a random sample of 200 citizens of the city of Vancouver. The questionnaire consisted of a series of items to be rated on a scale which related to a scenario devised by the authors. Thus, the respondents were being asked to assess participation preference on a hypothetical case study. Following factor analysis the authors suggest that the patient role-orientation preferences found in the study appear to fit with Szasz and Hollender's guidance-co-operation model, based on the identification of two main activity dimensions: information seeking and indirect particpation. The authors were unable to identify socioeconomic variables associated with role preference due to

> "The unexpected complexity of the interrelations between social economic variables and role preference" (p.133).

Although Vertinsky et al's study indicates that patient's do prefer active involvement at the guidance-co-operation level it is limited by the nature of the instrument developed for the research and the fact that it was not used in a practice setting. People who were in the patient role at the time of completing the questionnaire might have given different responses from people who were not involved with a clinician. The questionnaire itself was limited as it gave only one scenario on which to base orientation preference, upon which there could have been 200 different interpretations. Vertinsky and co-workers were writing before Kleinman's (1975)

publication of explanatory models theory but in the light of this work it seems probable that the respondents would each have applied his own explanatory model to the scenario presented which may have accounted for the complexity of socioeconomic variables. Nevertheless, this early study appears to indicate that patients do desire something more than a passive role in their health care.

A later study by Strull and colleagues (1984) used the clinical setting in order to measure the degree of preferred participation of patients and compared this with the doctor's assessment of patient preferences. A questionnaire was adminstered to 210 hypertensive out-patients which addressed their information requirements in relation to hypertension, additonal information, preferred therapy and participation in decision making. A similarly worded questionnaire was adminstered to practitioners including physicians, nurses and pharmacists. The instrument was self-completed which could give rise to problems of misinterpretation. Interestingly, this study showed that whilst 52% of patients reported having received "quite a lot of information" or "all there is to know" in relation to hypertension only 38% of clinicians reported giving this level of information. This finding takes no account of other sources of patient knowledge and it suggests, perhaps worryingly, that patients feel in possession of the knowledge needed to make a decision when they may not be. Interestingly, patients of nurses and pharmacists reported receiving significantly more information (66%) than patients of physicians (46%). Could it be that nurses and other health professionals are more willing to impart information than physicians? This question is not addressed by Strull's study. However, all clinicians were likely to under estimate the degree of discussion that patients preferred in relation to their therapy whilst over estimating the patient's preferences for actual decision making. Over half the patients (53%) wanted at least some involvement in decision making but 78% of the clinician responses fell in this category. Strull et al note that the patients in this study wanted more information and discussion but were not so strongly in favour of decision making. However, as the authors indicate, the desire to make decisions may not be fully realised until the patient feels he has the information he

needs to make the decision. As Brearley (1988) has pointed out in her comprehensive review of patient participation, non-participation may be a self-fulfilling prophecy as patients cannot participate in decision making without the necessary information and this makes them less likely to desire participation which in turn makes participation less likely to be offered. Strull and associates (1984) call upon clinicians to make accurate assessments of their patient's desires for information and discussion so that decision making can be individually approached.

The Krantz Health Opinion Survey (Krantz et al 1980) was designed to measure patients' desire for both behavioural involvement in health care and information. The scale consists of two subscales -Behavioural Involvement (9 items) and Information (7 items). The items were derived from a scale originally intended to measure physician's awareness of client desire for involvement in health care and items were eliminated following reliability testing with college students. Thus, the final scale is based on items derived from two selected social groups -doctors and college undergraduates. Validity testing of the scale was also carried out among undergraduates, so that no indication is given of the reliability or validity of the scale with groups throughout the social classes or ethnic groups etc. The authors claim, nevertheless, to have developed a valid scale for measuring client desire for involvement in health care. The claim rests on three validity studies carried out among college undergraduates. The list tested the hypothesis that students attending a medical self-help course would score more highly than resident students or students attending a minor illness clinic. The results showed that, indeed, the course attenders scored more highly than residents who in turn scored more highly than ethnic attenders.

A second study of the resident students reported number of visits to the clinic over the academic year showed that clinic attendance was negatively correlated with the Behavioural Involvement subscale, indicating that students who desire more involvement in their health care attend the minor illness clinic less often. The third study involved the nurses' report of the students behaviour during a clinic visit in terms

of question asking and attempts at self-treatment. The Information subscale was reliably related to question asking. The Behaviourial subscale was shown to be related to self-diagnosis and self-choice of medication. The authors conclude that discriminant validity exists between the two subscales since one does not validate the other in these areas. Whilst recognising that the scale needs further testing with chronic and serious illness, they apparently do not acknowledge the need for testing with a wider social spectrum of respondents.

Further testing of the Krantz scale (Smith et al 1984) in comparison with a new situation-specific measure for desire of control scale and a generalised scale found that the Information subscale of the Krantz Health Opinion Scale (HSO) was the best discriminator of a choice of place to die (home vs hospital) and type of preparation for childbirth. The other scales were found to be invalid in these specific contexts as was the Behaviourial Involvement subscale of the Krantz HOS. The authors question, however, whether the Information Subscale really measures desire for control as a style of behaviour since some of the items refer to descriptions of past information seeking behaviour rather than preference for it. They suggest that so long as the scale can discriminate between those wanting control and those who do not then face validity is unimportant and that further well-controlled experimental studies are required in this area.

Whilst the work of Krantz and co-authors (1980) and that of Smith et al (1984) goes some way towards developing a valid measure of desire for participation it leaves an unsatisfactory gap between instrument development and furthering the knowledge of the extent to which patients and clients desire more involvement in their health care. One further study which has used the Krantz Health Opinion Scale (Krantz et al 1980) is that of Pendelton and House (1984). These authors used the Krantz HOS to measure preferences for degree of involvement in health care of 47 low-income, inner city diabetic outpatients. Comparing these scores with three groups of well college students

significant differerences were found ; the diabetic patients having lower preferences for Behaviourial Involvement and information. Pendleton and House suggest that the difference is related to socio-economic status (including education), affliction with chronic illness and age. This study appears to redress some of the imbalance observed in the original validity studies of the scale (Krantz et al 1980). However, Pendleton and House (1984) do not attempt to estimate the level of involvement offered to the study patients. Thus, their apparent "lack of interest" in involvement could be a learned response to a health care system which does not expect involvement from patients with low social status and chronic illness.

Cassileth et al(1980) explored the degree to which cancer patients prefer to be informed about and to participate in their medical care. They found that the younger the patient, the more they wished to be informed and participate in decision making. Older patients and those more seriously ill preferred a less active role. These findings were based on a sample of 256 respondents who completed an Information Styles Questionnaire, designed to elicit data on patient information and participation preference, and the Beck Hopelessness Scale. which indicated that patients wishing to be involved in treatment decisions were significantly more hopeful than others. The majority of patients in each age group displayed high levels of hope, preference for open communication and a desire for maximum amounts of information.

A significant proportion of patients (half those in the 60 and over age group) indicated a preference for the physician making decisions. Cassileth et al tend to under report this finding.. Some elderly patients may perceive this to be the socially desirable response. A potential methodological problem with studies of patient preference for participation could well be that those who actively participate in a research study are more likely to be those preferring an active status. This is reflected in the response to Cassileth et al's study where 49 (17%) of the original patients approached refused to take part. These individuals could be people who prefer a non-participant role.

Haugh and Lavin (1979) conducted a survey of health-centre patients to estimate the extent of public challenge of physician authority. They also found that those preferring a more active role were younger, had a higher educational level and greater health knowledge. These findings were based on a sample of 640 respondents. More than half of these demonstrated attitudes tending to reject physicians' right to direct their interaction with patients. Challenging behaviour such as seeking a second opinion or expressing disagreement with recommendations occurred at least once for half the group.

Questions can be raised about the way they sought to identify a consumerist stance. For instance, to score at the low end of the attitudinal challenge scale one would have to endorse attitudes such as "obedience and respect for what doctors tell you is most important" and "every person should have complete faith in doctors and do what they tell you without a lot of questions". The range of behavioural challenges offered was rather narrow and extreme, such as changing doctors or actively seeking a second opinion. Such behavioural challenge does not take full account of the constraints which may oppose even the most actively disposed patient. For example, it can be extremely difficult to change doctors because of the power and control of the organisation which many patients may feel too ill or too powerless to challenge.

In Schulman's (1979) study already referred to, a scale to measure Active Patient Orientation (APO)was developed. This was used to investigate the relationship between varying APO levels and treatment outcomes in hypertensive outpatients . The APO scale attempts to measure how much participation was being offered. by the clinic staff. Few details of the scale are given in the account : it consists of 11 statements descriptive of the various aspects of APO ; for example "The staff give me very useful instructions for taking care of my blood pressure". Patients were asked to respond to each statement by indicating their agreement or disagreement on a four-point scale. Thus, the scale relies on the patient's subjective judgement of the usefulness of various aspects of the clinic staff's involvement with them and cannot be representative of the

true levels of participation preferences as, again, patients may select responses which are perceived to be socially desirable. For instance, some individuals may indicate that they found the staff's information useful but this gives no indication of either the quality of the information or the way in which it was given.This highlights one of the limitations of this study discussed earlier which was that Schulman did not collect any direct data from the physician-patient encounters in her study.

The studies discussed so far have largely been carried out within American primary health care systems. Dennis (1987) however has used the Krantz HOS (Krantz et al 1980) within the American hospital setting. She employed Q methodology alongside the KHOS involving a total of 70 patients (30 major, 30 replication and 10 test-retest subsets) who carried out two Q sorts and completed the KHOS, to assess their control preferences. The first Q sort under the condition of what was important for getting well/going home revealed that patients who wanted to have information about diagnostic tests and treatment did not necessarily want more decisional control, whilst patients who wanted more active involvement in decision making were less concerned about taking control over daily activities and the environment.

Three factors emerged from the second Q sort under the condition of making the stay more pleasant. These were similar to those in the first sort and included more knowledge about the expectations of the patient role and having more information, decisonal control and to have their needs met as they arose. The results of the KHOS supported the interpretation of the Q factors in that patients who wanted to be actively involved in making decisions tended to have higher total KHOS scores as well as the highest scores on the Information and Behavioural control subscales.

Dennis (1987) concludes that the patients in the study did want to have control over the people and events that had an impact on their well being and quality of life while they were in hospital. Whilst recognising the limitations of the study in terms of sample size

and distribution (most respondents were white, male and college educated) the author promotes the concept of client control and the role of the nurse in identifying patients who do desire involvement in decision making and those who do not. She also recommends that more attention should be paid by nurses to the dissemination of information. She does not however address the important issue of the level of control the nurse has in either giving information (particularly in relation to diagnosis and prognosis) or facilitating patients to make their own decisions.

Kim's study (1981) of patients' attitudes to collaborative decision making in nursing found that 71% (n=31) perceived that they had only minimally been included by nurses in making plans. Kim also found a negative relationship between the degree of participation in decision making and patients beliefs about their collaborative rights. This suggests that patient participation in care planning is more likely to be affected by what is "allowed" in the practise setting than the patients' own beliefs in this area. The study also revealed a trend towards more participation in care planning being related to greater satisfaction with nursing care. Whilst the findings of Kim's (1981) study suggests that patients desire more participation than they in fact engage in, the study was limited by its small sample size (n=31 for the first interview, n=17 for second interview) and its lack of information on dyad- relations. For example the study relied on the patient's perception of their involvement ; there was no direct observation of the nurse-patient interaction.

A later study by Kim (1985) looked at the nurses (n=152) attitudes towards patient participation and also at their reports of the degree to which collaboration is encouraged in practice. The study method involved a postal questionnaire sent out to a random sample (n=250) of registered nurses. A response rate of 56% (n=152) suggests that perhaps nurses who were interested in patient participation were more likely to respond. Even so, the results showed that whilst 43.4% of the sample believed that patients should be involved in joint decision making and almost half (49.3%) said that

this was their prefered practice very few believed or practiced total patient control. When asked to assess the level of usual practice in regard to participative decision making 46.1% reported "sometimes" compared to 27% "often" and none "always" and almost 82% reported that in practice the extent of the patient's influence on nursing care decision was either moderate or minimal. The results suggest that nurses are either not actualising their beliefs regarding participation or not expressing their true value structures regarding the collaborative role of the patients. Kim suggests that if nurses are, in fact, expressing their true values then it is possible that they do not have the skills required to involve their patients in planning care. Again, the interesting results of this study are limited by the poor response rate and the fact that no direct observation of nurses interacting with patients was available. It is possible that nurses underestimate the degree to which patients could collaborate in their care given the opportunity. An earlier study by Citron (1977) also found an inverse relationship between nurses beliefs about patients participation in decision making and their reported approach to every day routines. Citron suggests that the underlying reason for this is the educational process which holds to a theoretical ideal which nurses are unable to put into practice in the real situation. Citron 's analysis rests on the results of a 30-item questionnaire which, whilst reported to be both valid and reliable, gives neither the depth of interview data nor the direct evidence of observation.

Brooking (1986) conducted a study which both took into account patient's and relatives attitudes towards participation in care as well as nurses' attitudes to the topic and observation of their practice. Brooking was also concerned about the effect of the Nursing Process on both attitudes and practice in relation to patient and family participation in care. The research involved 107 nurses, 114 patients and 72 relatives in two London hospitals. Likert scales were developed to measure attitudes towards patient and family participation whilst direct observation of nursing practice took place in the ward. Brooking found that whilst nurses showed more favourable attitudes towards participation than either patients or relatives, that nevertheless patients or

relatives reported that they prefered to have more involvement in planning and implementing care than they currently experienced. As in previous studies (Citron 1977, Kim 1985), nurses claimed to organise their care to facilitate patient and family participation but there was little actual evidence of this. Brooking (1986) had the advantage over previously discussed work of actually observing the practice situation although this did not go so far as to gain detailed records of the nurse-patient or nurse-family interaction. Thus, little is known about the nurses' dialogue with the patients in relation to participation. Important questions remain to be answered such as did the nurse offer the patients options or give them sufficient information to make informed decisions about their care ? Or, indeed, did the nurses give patients or relatives the opportunities they might need to ask questions ?

An interesting finding from Brooking's work is the revelation that the use of the Nursing Process had a negligible effect on either practice or attitudes towards patient and family participation despite nurses having a favourable opinion towards the Nursing Process. This would seem to indicate that the process of assessing , planning and implementing care is perhaps regarded as a structure for organising nursing activities rather that collaborative activities. It is interesting to note that the nurses in Brooking's study had evidently failed to grasp the conceptual link between patient participation and individualised patient care implicit in the Nursing Process. However, perhaps this is not surprising when, as Walton (1986), points out the Nursing Process is both demanding and confusing.

A recent study by Waterworth and Luker (1990) has also explored the degree to which patients desire collaboration in their care. This was a small, in depth study involving a convenience sample of 12 patients from three medical wards. Using informal interviews the researchers collected information from the patients about their hospital experience including the patients' perceptions about their involvement in decision making concerning their care. Little information is provided by the authors about the

way in which the interviews were conducted, where they were carried out or the patient variables which may be significant such as age, sex and diagnosis. Reference is made to Grounded Theory (Glaser and Strauss 1967) but there is little discussion about theoretical sampling. The authors draw from their 12 interviews one theme which they perceive throws some light on how patients view collaboration. This they call "toeing the line". The authors argue that patients do not desire collaboration in decision making as much as has been previously thought. The patients in their study claim to just want to do as they are told and "toe the line". Waterworth and Luker (1990) present very little data to support their argument. They also make rather generalised statements in their conclusion by suggesting that "while active involvement of patients is encouraged, patients may comply with this approach even if they do not really want to".

This study made no observations about the nature of the nursing practice on the three wards and no comments about the organisation of care. It is therefore with extreme caution that one would draw inference from this study about the level of participation which patients desire.

Summary

There does, generally, appear to be a preference among patients and clients for more information and discussion and to a lesser degree for participation in decision making in their health care. However, there are variations among populations, possibly related to age and socio-economic status and individual differences related to personality/style expectations. The methods used in the studies discussed have been limited by sample size and distribution and sometimes by the use of tools needing further development and by the lack of direct evidence. Whilst many of the studies have been conducted in North American Primary Health care systems there is still little available evidence about the preferences of British users of the health care system. Some nursing research appears to be emerging in relation to patient preference for

involvement in care planning -this could be extended into the community context. Certainly more descriptive data of the current levels of participation and desires of clients needs to be considered.

Conclusions

This chapter has addressed the concept central to the current study that is, client participation in health care. The nature of the concept has been explored, its effectiveness in practice and its desirability by patients and clients. The review has concentrated selectively on studies which address the nature of participation between a health professional and client/patient. This was seen to be most relevant to the current study of participation in health visiting. However, it is recognised that participation at community level is of growing importance and that further studies to enhance those by Drennan (1985) and Brownlea (1987) for example, are required particularly in relation to increasing an understanding of these issues in primary health care.

It appears that there is a clear need for further research in this area. The concept of patient/client participation has been defined and operationalized in various ways and it is therefore difficult to know, for example, if apparent differences in the participation preferences of different patient groups (e.g. Cassileth 1980, Faden 1981) are genuine or were reflections of different assessment procedures. Efforts need to be made to formulate a standardized definition of the active patient concept and to develop reliable and valid measures of patient's participation preferences. There is also a need for more descriptive data on the way that health professionals currently attempt to promote participation of their patients and clients. Only then will it be possible to assess the efficacy of the approach and to put policy recommendations into practice through refinement of methods and application.

Steele and colleagues (1987) have pointed out that much of the research to date has been atheoretical which has contributed to terminological confusion, non-comparable

operational definitions and difficulty in explaining research findings. These authors point to the guidance that a theoretical framework offers in organising and understanding observations, pinpointing the questions that need to be asked about patient relationships and suggesting methods for pursuing answers to these questions. Steele and colleagues (1987) also advocate a self-regulatory perspective such as Bandura's (1977) theory of self-efficacy but recognise that other theoretical perspectives may have value. In conclusion, this review leaves many questions still to be answered about patient/client participation and the current study attempts to address questions such as to what extent do practitioners elicit client participation from a Health Visiting perspective.

Conclusion of literature review.

This review of the issues relevant to client participation in health visiting has addressed the four main areas of historical developments in health visiting, the nature of health visiting practice, the evaluation of health visiting and the concept of client participation in health care.

The development of health visiting as a profession and the changes which have potential influence on practice have been explored. This has highlighted the possibility that health visiting is returning to a more collectivist approach to health promotion and as such needs to consider the concept of client participation in this context. The Health Visiting Process has been promoted as a way of enhancing client participation and this review has critically analysed the existing research in this area .The need for further research into the influence on practice of the Health Visiting Process has been identified.

Studies which have explored the nature of health visiting practice in terms of what health visitors do and how they do it have been reviewed. It is clear from this review that there continues to be a relatively small body of literature which addresses the process of health visiting and particularly with reference to client participation. The need to examine this perspective further was therefore identified, especially in the light of forthcoming changes in the Health Service (NHS and Community Care Bill, 1990). Potentially, the more detailed analysis which is available on health visiting practice the better position health visitors will be in to define for themselves the role they want for the future. Such a role must take account of client views and requirements.

It is extremely difficult to measure the outcomes of preventative care and this has been discussed in tthe context of reviewing studies which have evaluated health visiting practice. However, in order to survive the coming changes in the Health Service , health visitors will need to demonstrate their worth and maintain their important role in

health promotion. The views of the consumers of health visiting are seen to be significant in this respect and much of the literature under discussion has indicated that the current style of health visiting is unacceptable to many people. It is therefore important to explore the usefulness to practice of frameworks such as the Health Visting Process as the key to future role of the health visitor would appear to lie with a more participative approach. Conceptual frameworks which enable this approach may need to be developed.

An overview of the literature relevant to client participation revealed that much of this research has been based on doctor-patient relationships in the U.S.A.. This highlights the need for further enquiry in the U.K., particularly in nursing. From the existing literature it appears that, in general, clients do desire a more active role in their health care and that participation may contribute to beneficial health outcomes. However, this is by no means a clear-cut issue.

The current study therefore aims to explore client participation in health visiting and the influence, if any, of the Health Visiting Process on the application of this concept. The domain of the health visitor-client interaction has been selected as the primary source of data for investigating this phenomena, as it appears from the literature that this is where the majority of health visiting activity occurs. It is also perceived to be the point at which the client potentially has most opportunity to participate, as indicated by the previous studies discussed on doctor-patient negotiation. An understanding of this aspect of health visiting was perceived to be vital if health visitors are to develop and maintain a specialist role in health promotion in the future.

Methods

Introduction

The overall purpose of the current study was to enhance an understanding of the health visitor-client interaction focussing on the concept of participation and the influence of the health visiting process.

The specific aims of the study were formulated as follows:

- To explore and compare health visitors and clients perceptions of a visit.
- To describe the health visitor-client interaction from the perspective of client participation .
- To compare practice between health visitors using the Health Visiting Process (HVP) and health visitors using "traditional" methods.

The link beetween the aims was seen to be the concept of participation which for the purposes of definition can be understood to mean to:

> "achieve patient/client involvement in problem identification and prioritization, in the establishment of change objectives and in the process of making decisions about how change will be accomplished". (D'Onofrio, 1980 : 274)

This definition, as discussed previously, was perceived to be most appropriate to a study of health visiting practice as it encapsulates a health promotion approach and enables participation to be explored at the level of the interaction. As suggested by Greenfield et al (1985), this is the point where, potentially, clients can have most impact on their care.

Approach to the study

The nature of this research demanded the close examination of what actually occurs between an health visitor and a client. This in turn suggested that the methods used should provide data of a rich and detailed nature which would lend themselves to a variety of analyses. In view of the aims of the study a variety of qualitative approaches were considered. These are briefly discussed below in order to clarify the position finally taken by the researcher.

Grounded Theory

Grounded theory is a qualitative approach to the research method formulated by Glaser & Strauss (1967). The basic tenet of the approach is the generation of substantive theory from the data:

> "generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically marked out in relation to the data"
> (Glaser and Strauss, 1967 : 1)

Glaser and Strauss describe a process of comparative analysis from which themes and eventually theory emerges. Once themes or categories start to emerge from the data they are used in order to direct further data collection, a process described by Glaser and Strauss as "theoretical sampling":

> "the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them in order to develop his theory as it emerges"
> (Glaser & Strauss 1965, cited by Melia 1982)

The categories are the conceptual elements of the theory and are said to be saturated when no new data are found which further develop the categories. The sample is not numerically predetermined but determined by the development of the categories. Thus, the emergent, inductive theory can be seen to explain the data in a way which a deductive approach does not allow. Whilst the grounded theory approach has been used to some extent by other nurse researchers (Melia 1982, Clark 1985, Chenitz and Swanson1984) it was observed by this researcher that the rigorous process of entering a

substantive field without predefined hypotheses or formal theories and generating theory thereby grounded in the data was not without its limitations. In most cases, previous researchers have had to adapt the approach to suit the needs of their own area of inquiry, which in some cases has necessitated the need to work outside the basic tenets suggested by Glaser and Strauss. Clark (1985), for example, could not use the constant comparative approach for category development as the data had already been collected.

For these reasons and, because at this stage the current study was not designed to generate a theory of health visiting, the grounded theory approach was rejected.

Ethnography

Ethnography is a research approach developed from the field of anthropology. It is a rationalistic comparative method aimed at studying human behaviour and attitudes through observations in the natural setting. Leininger (1985) has described ethnography as:

> "the systematic process of observing, detailing, describing, documenting and analysing the lifeways or particular patterns of a culture (or subculture) in order to grasp the lifeways or patterns of the people in their familiar environment".
> (Leininger 1985 : 35)

Whilst the approach has been widely used in anthropology and sociology it has only relatively recently been adopted by nurses, but has been shown by some studies to have relevant application to nursing practice (Field 1983, Robertson and Boyle 1984). The traditional method of data collection in the use of the ethnographic approach is participant observation as this is seen to be the most naturalistic way of understanding a particular culture. However, participant observation was not considered appropriate for this study as recording of the health visitor-client interaction was a critical aspect of the data. Recording of these dyadic interactions placed the researcher in the role of non-participant observer.

Leininger (1985) has formulated a specific approach to nursing, derived from ethnography, which she calls "ethnonursing". She describes ethnonursing as:

> "the study and analysis of the local or indigenous peoples' viewpoints, beliefs and practices about nursing care phenomena and processes of designated cultures".
> (Leininger 1985 : 38)

This specific approach was conceptualised and developed in order to focus primarily on the documenting, describing and explaining of nursing phenomena. Whilst it has implications for the current study, Leininger does not make it clear why a specific approach for nursing is necessary and it calls into question whether there is also a need for ethnopolicing or ethnosocial work for example. With reference to validity and reliability of the enthnographic approach, Leininger (1985) suggests that the goal of such a study is knowing and understanding the phenomena rather than measuring it and that therefore validity refers to gaining such knowledge and understanding and documenting accurately relevant and consistent features. The inherent danger here is that the researcher may assume the study to be both reliable and valid simply by stating that the domain of inquiry has been intensively observed and recording the findings. A possible weakness of the ethnographic approach is that the reader of the research cannot validate the findings for herself without a detailed display of the data which, by its very nature, may not be provided. Other validating measures are therefore called for. Nevertheless, it was considered that some aspects of ethnography had application to the current study, notably the need to study health visiting practice in its natural setting i.e. in the client's home. It was also considered that, despite the existence of a small number of previous studies in the area (Warner 1984, Clark 1985, Sefi 1985, Robinson 1987), that there were gaps and inconsistencies in the status of knowledge and understanding of health visiting practice which could, to some extent, be resolved by some further descriptive work in the field. The ethnographic approach appeared to offer some of the necessary framework within which to enhance an understanding of health visiting practice.

Ethnomethodology

One further approach explored was that of ethnomethodology. This approach was formulated by the American sociologist Garfinkel (1967). Whilst ethnomethodology remains essentially inductive in its approach, its value lies in its attempt to offer a more rigorous and systematic method of data analysis and display. This is particularly true of one branch of the approach which has been adopted by several sociologists in the U.K. and utilised in nursing research - that of conversation analysis developed by Sacks, Schegloff and Jefferson (1974).

Conversation analysis as promoted by British sociologists such as Heritage (1984) provides a rigorous, microanalytical approach to the study of verbal interaction which has obvious implications for the current study.

Heritage (1984) has summarised the three fundamental assumptions of conversation analysis:

1 Interaction is structurally organised.

2 Contributions to interaction are contextually orientated

3 These two properties inhere in the detail of interactions so that no order of detail can be dismissed, a priori, as accidental or irrelevant.

Thus, this school of ethnomethodology assumes that people are competent in the organisation of social life and this competence is displayed in their production and interpretation of conversation. Montgomery Robinson (1987) in her ethnomethodological study of health visiting cites, as an example of this, the health visitor's and client's competence in recognising and interpreting health visitor talk to the extent that in one case analysis presented by Montogmery Robinson the health visitor gains entry to the home within 75 seconds "just" through talk.

Whilst there appeared to be clear relevancies in adopting the ethnomethodological approach for the current study some inherent limitations were recognised. Firstly, there appears to be a tendency within the tradition to analyse talk for its own sake to further the methodology rather than to further the knowledge status of the area under study. In the current study, the overall purpose was to further the understanding of the nature of the health visitor-client interaction, not to develop the school of conversation analysis. Secondly, there appears to be a problem of interpretation. This can be illustrated by reference to Montgomery Robinson (1987). In her attempt to describe the health visitor as a competent and skilled negotiator, Montgomery Robinson appears to ignore alternative interpretations. In the example previously mentioned, the fact that the health visitor entered a home she was visiting for the first time and saw the baby within 75 seconds was interpreted by Montgomery Robinson as a skilled action. Montgomery Robinson does not appear to consider the alternative interpretation that the health visitor was "pushing" her way into the home of a client who was neither expecting her or knew of her purpose. Thus, the basic assumptions of the ethnomethodologist as outlined by Heritage (1984) could be seen to constrain interpretation of the data. Finally, there were aspects of the current study which were not directly related to the analysis of talk, such as enhancing understanding of the client's and health visitors's perceptions of a visit.

It was therefore decided that a purely ethnomethodological approach to the current study was not appropriate, although some principles of conversation analysis could be applied.

Triangulation

Whilst collection of the data for this study demanded a primarily qualitative approach, it was recognised that more than one type of data could enhance the validity of the study. For this reason, in order to meet the study aims, not only were recordings of health visitor-client talk collected but also interview data from both health visitors and clients. It appears that no previous studies of the health visitor-client interaction have attempted to validate data in this way.

Denzin (1978) has broadly defined this approach known as triangulation as:

> "the considerations of methodology in the study of the same phenomenon" (Denzin 1978 : 291)

The case for triangulation arises from the position that no single approach resolves questions which arise from observations of complex social situations, of which the practice of health visiting is an example. Observations made from separate vantage points support comparison, allowing the researcher to determine whether each reflects the same object. There is, therefore, a greater possibility that the research findings will be valid.

Miles and Huberman (1984) suggest that in order for triangulation in qualitative research to be useful, there must be several different kinds of measures which provide repeated verification. Thus the indices chosen should be independent, sturdy, of different types and sources and congruent. Therefore, for the purposes of this study, the data were collected in the following forms:

1 Audio recordings of the health visitor-client interaction (qualitative).

2 Observation of health visitors and clients interacting (qualitative).

3 Semi-structured interviews with health visitors about their perceptions of avisit (quantitative).

4 Semi-structured interviews with clients about their perceptions of a visit (quantitative).

5 Semi-structured interview with health visitors about their perceptions of related concepts e.g. participation (qualitative).

In order to meet Jicks' (1979) characterisation of triangulated data sets which he described as those:

> "capable of providing a holistic or contextual description of the phenomenon under scrutiny including reliability and validity". (Jicks, 1978 : 603)

the data analysis was approached from both qualitative and quantitive perspectives as indicated. Although triangulation has not been widely used in health visiting research, a paper by Sohier (1988) which addressed psycho-social development of children concluded that:

> "triangulation provides a contemporary logic for increasing consistency between the philosophical foundations of nursing, its emerging formulations and the research tradition". (Sohier 1988 : 741)

Other approaches to triangulation such as the involvement of more than one researcher were considered impractical for this study and, additionally, whilst eliminating some researcher bias, could introduce reliability problems between researchers.

Towards Elcecticism

In summary the approach adopted for the purposes of this study was eclectic. It was decided, for the reasons outlined, that no one approach was entirely appropriate and that to "label" the research as coming from one particular school could in fact have a constraining effect. There were however, aspects of both the ethnographic and ethnomethodological approaches, which appeared to have application to the current study most notably the emphasis on collecting data in its natural setting. These approaches alone, however, were not considered adequate to fulfill the aims of the study and therefore a quantitative approach was taken towards some aspects of the

data analysis. This, it was considered, would provide a degree of triangulation thereby enhancing the reliability and validity of the study.

Data collection methods

The actual data collection methods used in this study are described in more detail below:

Audio recording of health visitor-client interaction

In order to meet the primary aims of the research, that is to describe and explore the nature of the health visitor-client interaction from the perspective of client participation, the most appropriate method of collecting data was considered to be audio-recording. This decision was taken for several reasons. Firstly, the method has been used by a number of previous researchers both within and outside nursing. There is general consensus that the method is reliable in as far as the technology allows, for collecting detailed and verbatim conversational data. (See, for example, Macleod Clark 1982, Baldock and Prior 1981, Tuckett et al 1982, Clark 1984, Warner 1984, Sefi 1985, Montgomery Robinson 1987). Earlier research by Kratz (1975), demonstrated by contrast that interactional data collected by observation and field notes alone did not provide the same depth or reliability of data as tape-recording could potentially provide.

Heritage (1984) has outlined four major advantages of tape-recorded data:

> 1. The recorded data, which is an accurate account, can be studied many times by the researcher, enabling precise observations to be made which are also capable of revision.
>
> 2. The data, which has not been subject to the limitations of recollection or intuition, can be examined in minute detail.
>
> 3. Other people can also have direct access to the data and form their own opinions of it.
>
> 4. The data represent a permanent record, which can be used by other investigators, or re-examined in the context of new findings.
>
> (Heritage 1984 : 238)

Whilst these advantages were pertinent to the current study, some drawbacks of the method had also to be born in mind. Firstly considered was the effect that using a device to record what, potentially, could be an intimate conversation, may have on the participants. It is possible that either health visitors or clients would not interact "naturally" thus distorting the data in some way. However, evidence from research previously cited appeared to indicate that the introduction of recording equipment did not significantly affect the interaction, especially when its presence was minimized as in the use of radio-microphones. This was also the researcher's own experience from a previous study of nurses' health education interactions (Macleod Clark, Haverty and Kendall 1987). A second possible disadvantage is the ethical implication of recording permanently a potentially private conversation. This problem was overcome by obtaining formal consent from both health visitors and clients and by presenting the study to the District Ethical Committees. This is discussed in more detail later.

A third disadvantage of audio recording is that it captures only verbal interaction and thus much of the non-verbal communication between participants is not recorded and also much of the contextual flavour of the interaction is lost. This posed the possibility of using video-recording for collection of data. Video-recording certainly presents the attraction of capturing for detailed analysis all aspects of an interaction. It has been used with some success by Chalmers and Kristjanson (1987) and Mallet (1987) in nursing research. It also has disadvantages in terms of reliability and analysis. The introduction of video cameras into the home presents a much greater imposition than discrete microphones and may, additionally, necessitate lighting equipment. Setting up such equipment to ensure the correct angle of vision may disturb natural positioning of the participants and the process of interaction. Overall, this kind of equipment, which would have to be set up on each home visit, seems more likely to disturb the naturalistic setting than audio-recording. In the analysis of video-recordings it is possible that the researcher will become so engrossed with the non-verbal aspects that an inordinate amount of time may be devoted to the minute

movements of one hand for example, rather than the overall interaction. Sefi (personal communication, 1989) has also pointed out the problems of interpretation of video material - it can only be observed through the camera's eye and a very different picture may emerge if the interaction were viewed from a different angle.

It was, therefore, felt that overall the the advantages of audio recording outweighed those of video recording, particularly when data collection took place in client's private home. The main consideration was that, whilst recognising the importance of non-verbal communication, this study was primarily concerned with the verbal interaction. In order to minimise inconvenience to participants and to enhance the quality of the recordings, it was decided to use professional-quality radio microhones (Minkom) which could be discretely worn by the health visitor. The recorder itself was again of professional quality - the Sony TCM. The equipment was all battery driven, eliminating the need to impose on client's electricity supply or have unnecessary cables trailing in their homes where young children would inevitably be present. This, however, presented the occasional problems of batteries expiring during an interaction which meant that the researcher had to be very efficient at checking and maintaining the equipment.

Non-participant observation

It was envisaged that one way of overcoming some of the disadvantages of audio recording without introducing the complexity of video equipment would be for the researcher to be present in a non-participative role. This approach enabled the researcher to make notes on the context of the visit and thus provide a fuller picture of the interaction than audio-recording alone could offer. The role of observer has largely been considered in the literature in terms of participant observation rather than non-participant observation. Becker and Geer (1965) for example, have contrasted participant observation with interviewing. They suggest that the advantages of participant observation lie in the need for the researcher to become

familiar with the "native language" which will mean that inferences and definitions will be more meaningful than by interviewing alone. In the current study, it was felt that whilst the researcher was in a non-participant role it was stll important that she was familiar with health visiting language and customs. The fact that the researcher had a health visiting background meant that to a large extent she was already familiar with the nuances and subtleties of health visitor talk. Becker and Geer (1965) also suggest that interviewees are not always willing to discuss some matters with an interviewer but that an observer can see for herself factors that might be overlooked by the interviewee. The presence of an observer reduces the inferential bias that may be introduced by interviewing alone. In this study it was felt that non-participant observation could equally meet this aim, particularly as the main data set was permenently recorded on audio-tape.

A third advantage of observation over interviewing perceived by Becker and Geer (1965) is that the observer can check facts which an interviewee may report through "distorting lenses" - in other words the context, content or process of a situation may be misrepresented by interview alone. Again, in the current study it was felt that the presence of the researcher as observer reduced the risk of either health visitor or client distorting the nature of the interaction in subsequent interviews and also allowed the researcher to cross check information provided in later interviews with both the audio-recorded material and her own experience of the interaction. Overall, for the purposes of this study it was felt that non-participant observation was the most appropriate role to be adopted as it enabled the points made by Becker and Geer to be met whilst not directly taking part in the interaction. Also, the role of complete participant as described by Junker (1960) was not appropriate for the present study:

> "In the role of the complete participant his true identity and purpose are not known to those he observes"

Clearly, it was not possible for the researcher to accompany health visitors on home visits without their knowledge of the identity of the researcher and the broad nature of the inquiry. In contrast, the role of complete observer was equally inappropriate since the researcher could not "see without being seen". Thus, the approach adopted was, as prescribed by Junker, the observer-as-participant. Kratz (1975) has discussed the possible distortions of an interaction which can occur when it changes from a dyadic to a triadic situation. She bases her argument on the work of Simmel (1964) which suggests that a dyadic interaction (between two individuals or two groups) has the specific feature of intimacy which may be completely altered by the presence of a third person. Thus, in the present study it was seen as important to maintain the dyadic nature of the health visitor-client interaction whilst retaining an observational role for the researcher. Therefore, in practice, the researcher positioned herself discretely in the room out of direct eye contact of either health visitor or client, but in such a way that the contextual complexities of the interaction could be observed.

Disadvantages of this approach can be identified. The main disadvantage is the possibility that the very presence of the observer would distort the naturalistic setting which the researcher aimed to achieve. This was minimized to some extent by the fact that it is not "unnatural" for health visitors to have a third person accompanying them on visits. Health visitors frequently take student nurses, health visitors, midwives and doctors into their clients homes. Such a visitor would not be expected to take a major role in the interaction and would, in effect, be an observer. Thus, health visitors and clients alike were not unused to the presence of an observer. Field and Morse (1985) suggest that the possibility of distortion through the presence of an observer is reduced over time as trust builds up and the threat of being observed is reduced.

In the experience of the researcher, this trusting relationship was felt to develop very quickly between health visitor and researcher. This was enhanced by the fact that the researcher was present on a series of visits. Health visitors and clients both reported that their awareness of the researcher's presence was minimal.

A further drawback of observation is the possibility that the observer may observe unethical practice and judgements and decisions have to be made about how to respond to such a situation. It is more difficult in a situation such as health visiting where the nature of the practice is principally health promotion and advice to make moral judgements about what constitutes acceptable practice. The researcher had to make some decisions, *a priori*, about the point at which intervention would be appropriate. These were seen to be where a child's health or life were put at risk through unsafe advice or negligence of a potential child abuse situation. The difficulties of judging such situations were never underestimated, but in the event these situations did not arise.

In summary, the role of observer-as-participant was judged to be appropriate for this researcher and that the advantages that if offered outweighed the potential disadvantages. For, as Becker and Geer (1965) have suggested:

> "Inference can never be more accurate than through direct observations".

Semi-structured Interviews

Whilst audio-recording and observation were the most appropriate methods for collecting data on the nature of the health visitor-client interaction, the most appropriate method for exploring the health visitors and clients perceptions of each visit and the health visitors understanding of health visiting concepts was felt to be semi-structured interviews.

There were two main domains in which interview data were seen to be most appropriate - comparing health visitors and clients perceptions of an individual visit and exploring the health visitors perceptions and definitions of concepts relevant to practice such as participation and HVP. Both interviews also allowed for some demographic data to be collected from both health visitors and clients.

The semi-structured, or guided, interview was selected in preference to the open interview technique because it ensures that all the information required is obtained whilst permitting the informant freedom of response and description to illustrate concepts. Unlike open interviews, all respondents in a semi-structured interview are asked the same questions so that responses may be coded, tabulated and descriptive statistics used to examine the data. This was considered to be an important aspect of triangulation.

The disadvantages of interviewing as perceived by Becker and Geer (1965) have already been discussed in relation to observation, but to summarise they are:

Difficulty of interpretation of meaning of the informant.

Some issues may not be readily discussed by informant.

Informants may distort the facts to the interviewer.

Problems of contextual ambiguity and inference.

Whilst recognizing these difficulties, the researcher felt they could be minimized by the facts that she herself was a health visitor and therefore had a good understanding of the language and process of the type of interaction under study and also that the interview was being used in conjunction with other methods. As Trow (1965) has pointed out in response to Becker and Geer's paper, some elements of social life may be missed by observation but picked up by interview and also interviewing gives respondents an opportunity to use their past experience in their explanation of particular phenomena - which observation alone cannot do.

It was decided that the interviews would not be tape recorded but that the interviewer would make detailed notes on responses. It was accepted that this would inevitably mean that some data would be lost, but that it was felt to be possible to gather enough information to make meaningful inferences.

Design of the semi-structured interviews

Three interview schedules were designed, comprising:

Client's perceptions of a visit (CQ)

Health visitors perceptions of a visit (HVQ)

Health visitors perceptions of concepts relevant to health visiting practice (HVI)

Client's perceptions of a visit (Appendix 4)

This interview schedule is identified as the client questionnaire (CQ). Since the primary purpose of this instrument was to reach some understanding of the client's percieved experience of a visit, the open questions included in the schedule were designed around a framework of health visiting process (HVP) although formulated in language that would be clear to the client. For example, clients were asked "why do you think the health visitor came to see you today?" rather than "What were the health visitors primary objectives for this visit?" It was important to use the HVP as a basic

framework for the interview as it provided a logical structure which related to the aims of the study, that is to compare approaches between health visitors using the HVP and those using traditional approaches. Thus, clients were asked about perceived purpose (objectives) of a visit, their perceived problems/needs (assessment), the advice or action recommended (plan) and perceived follow up (evaluation). The CQ also provided an opportunity to collect relevant demographic data. This part of the schedule included some closed questions.

Health Visitor's perception of a visit (Appendix 3)

This interview schedule was identified as the health visitor questionnaire (HVQ) and followed a very similar format to the CQ. This design provided the opportunity for health visitors and clients responses to be directly compared so that an analysis of the extent to which health visitors and clients concur about their perceptions of a visit could be undertaken. Thus, a HVP framework was used to structure the HVQ design and health visitors were also asked open questions about their perceptions of objectives of a visit, client needs, planning and evaluation.

Health visitor's perceptions of concepts relevant to practice (Appendix 5)

This interview schedule was more detailed and identified as the Health Visitor Interview (HVI). It was designed to explore health visitors' understanding and their explanations of, concepts such as participation, enabling and the health visiting process. It was felt that it was necessary to explore these concepts in order to assist interpretation on the interaction data in relation to client participation and the HVP, particularly where comparisons were being drawn. The health visitors were also asked to relate their perceptions to practice - for example, to explain what advantages they experience in client care by using the HVP. The HVI was constructed using open ended questions, apart from a short section which related to demographic data about the health visitors. This demographic data was important as it provided an

opportunity to explore all the accepted sociological groupings (e.g. age, sex, class) in relation to all other data. This aspect of the data collection involved closed questions.

Reliability and validity of the data collection tools

Audio-recorded data and HVI

Essentially, these data were collected with the primary purpose of exploring health visitor-client interactions by focussing on the qualitative components which affect client participation. These data were not therefore collected with the goal of measurement in mind but rather with the aim of:

> "identifying and documenting relevant, accurate and consistent (homogenous) or inconsistent (heterogenous) features, as patterns, themes, values, world views, experiences and other phenomena confirmed in similar or different contexts". (Leininger, 1985 : 69)

Leininger in fact suggests that it is this process which enhances the reliability of qualitative data. The reliability of the method was also increased by developing the approach from the exploratory phase of the study through the pilot study and finally amended for the main study. Such factors as positioning of the recording equipment and the researcher were taken into account. The researcher also checked with the health visitors and clients in the pilot study the extent to which they perceived themselves to be influenced by the presence of the tape-recorder and the researcher. This was found to be minimal, suggesting that the possibility of bias was reduced. Leininger (1985) has described validity of qualitative data as "gaining knowledge and understanding of the true nature, essence, meanings, attributes and characteristics of a particular phenomenon under study" (Leininger 1985 : 68). Again, measurement is not the goal and therefore statistical tests for validity of construct and context are not appropriate for this type of data collection. Reliability and validity of qualitative data has also been addressed by Hinds et al (1990). They describe an evaluative approach to measuring realiability and validity of qualitative data which involves computing a coefficient of agreement between panels of objective raters using a four-staged approach. The system was described as quick and cheap. Its effectiveness,

however, is presented through an analysis of the realiability and validity of four qualitative studies each of which were conducted by the authors themselves. This invalidates their system to some extent as a more objective test would have been to test the reliability and validity of several qualitative studies in which the authors had no involvement. Whilst there were some strengths in this approach described by Hinds et al (1990) it was felt to be too limited for the current study and therefore triangulation and inter-rater reliability measures were seen as appropriate approaches to assuring reliability and validity of qualitative data in this study. Finally, the data collected by this method could both validate and be validated by the other data collection approaches, demonstrating that there was both consistency in the method and that the knowledge gained related to the reality of the situation under study.

Interview schedules -CQ and HVQ

Polit and Hungler (1987) have described reliability of quantitative measures as "the degree of consistency with which it measures the attribute it is supposed to be measuring" (p.316). There are three essential components to reliability - stability, consistency and equivalence.

As Polit and Hungler (1987) indicate, stability refers to the extent to which the same results are obtained on repeated administration of the instrument. One approach to assessing the stability of an instrument over time is the test-retest technique. This involves testing the instrument twice on the same group of people within a time period which Polit and Hungler suggest should not be more than two months. The reliabilty co-efficient for test-retest estimates is the correlation co-efficient between the two scores. This can be computed. However, for the purposes of this study the test-retest technique was not seen to be appropriate. This was due to the nature of the data which referred to perceptions of a specific home visit. It was felt that any time gap between administrations of the interview would alter individuals' perceptions of the visit. For example, memory, mood, subsequent discussion with other family members or changes in health status could all influence the individual's perceptions of a visit.

Indeed, Polit and Hungler (1987) recognise such factors as being disadvantages of the test-retest approach. Such changes over time may be independent of the stability of the instrument rendering the test-retest technique weak.

The test of reliability of the CQ and HVQ was therefore the split-half technique, a measure of internal consistency. This approach has the advantage of requiring only one test administration. In this test the items are split into two groups, scored independently, and the scores on the two half tests are used to compute a correlation co-efficient. It was perceived to be a more appropriate approach to reliability for these interview schedules, as internal consistency relates to the the critical attribute being measured by all the items within the instrument. In this case the critical attribute was perceptions of a home visit. Therefore, with the HVQ items 3-8 were split between odds and evens and with the CQ items 7-14 were split in the same way. Remaining items were not directly attributable to perceptions of the home visit as they included aspects of demographic data. The computed correlation co-efficient for the HVQ was 0.66 and for the CQ was 0.62. These were acceptable levels of internal consistency, indicating that the instruments were reliable. However, as Polit and Hungler (1987) point out, the split half technique is more reliable for longer instruments than shorter ones due to the nature of the test. Therefore whilst the HVQ and CQ were seen to have internal consistency, this was seen to have potential limitations because of the relatively short nature of the instruments.

Validity of an instrument, according to Polit and Hungler (1987) is the degree to which an instrument measures what it set out to measure. To what extent did the HVQ and CQ measure the health visitors' and clients' perceptions of a visit? This was firstly ascertained through the concept of face validity. Face validity is the degree to which an instrument makes sense to an independent observer. Face validity was thus established by exposing the instruments to other nurse researchers. Their comments suggested that the instruments made sense to them and therefore had face validity. The same nurse researchers also contributed to establishing content validity of the schedules. Since the items addressing perceptions were based on the four stages of the

Nursing Process, it was important to establish that the wording of the questions accurately reflected such content. This is normally established first by using the available literature in the formulation of items followed by the comments and observations of independent experts. This process was carried out and, following adjustments made after the pilot study discussed below, both the instruments were found to have content validity.

It was therefore accepted that, within given limitations, the HVQ and CQ were reliable and valid instruments for collecting data about clients' and health visitors' perceptions of a home visit.

Ethical issues

The RCN (1977) guidelines on conducting research in nursing suggest a number of ethical issues which should be addressed by the researcher during the conduct of the research and finally in its publication.

The current study raised a number of issues which needed to be considered in order that no harm (physical or psychological) should come to the respondents. The first consideration was one of consent. The nature of any research project demands that participants should be both informed about the study and give their consent to enter. The nature of the data collection in this study gave rise to particular concern as data was being magnetically and permenently recorded on audio-tape. Thus, normally private talk was potentially being made public. This could lead to undesirable consequences for both health visitor and client. It was therefore important to assure that both health visitor and client were aware of the nature of the research and the nature of the data collection instrument. It was particularly important to reassure the participants of the confidentiality of the data . Burnard and Chapman (1988) have discussed the concept of confidentiality in relation to the Professional Code of Conduct (UKCC, 1984). As the authors point out, the central element of confidentiality is the concept of trust. If a relationship of trust does not exist between a client and a health

professional then assurances of confidentiality are limited and the client is unlikely to divulge information which is essential to promoting her well-being. This is particularly relevant to the nurse researcher where the researcher is relying on gathering accurate and reliable data in order to answer the research question and ultimately to make recommendations for nursing practice. In the current study, a trusting relationship was eastablished with the responding health visitors by meeting with them on two occasions before the research commenced, answering their questions and giving them an opportunity to voice their anxieties about the study. It was not possible to meet all the clients before the study commenced and therefore they were being asked to trust the researcher through the nature of their own relationships with their health visitors. As Burnard. and Chapman (1988) point out, there are potential dilemmas associated with confidentiality. The Code of Professional Conduct (UKCC, 1984) allows the nurse to disclose information when required by law, when ordered by a court or when it is in the public interest. The third clause poses a dilemma for the nurse in that she has to make a judgement about what is best for the individual and what is in the best interests of society. For example, in this study it was potentially possible that information could have been passed on to the researcher related to child abuse. In such a case the researcher would have had to have made a decision about whether to disclose such information in the interests of the child and society. Fortunately, no such dilemma arose in practice but such issues need to be thought through before any research study is undertaken.

A consent form was designed (see Appendices 1 and 2) which outlined the research to the participants. Detailed information about the study was not given in order to reduce reactivity on the part of the clients. A second ethical issue to be considered was the presence of the researcher during the interaction and whether this would be perceived as an invasion of the client's privacy. Again, by discussing the study with the respondents it was felt that by consenting to be in the study the health visitors and clients accepted that a third person would be party to their conversation.

A third consideration as mentioned earlier was one of the role of the researcher in the event of "bad practice" being observed. This involved making an *a priori* decision about what was meant by "bad practice" and at what stage the researcher would intervene.

The decision was made by the researcher that if any potentially life threatening or seriously dangerous situations were observed where the health visitor was either giving the wrong advice or neglecting a problem then the researcher would intervene. This in itself raises further issues concerning the researchers level of knowledge about the families - in most cases only an outline of the family was given to the researcher prior to the visit. It could have therefore been potentially hazardous for the researcher to intervene in a situation where lack of knowledge or understanding on her part led to a misinterpretation of events. The relationship between the health visitor and client could have been destroyed by the researcher under such circumstances. Fortunately, no such situation arose.

Such issues were considered prior to carrying out the pilot study as the proposal for the study was submitted to the District Ethical Committees for their consideration and subsequent approval, the details of which are discussed later in this chapter.

Design of the Study

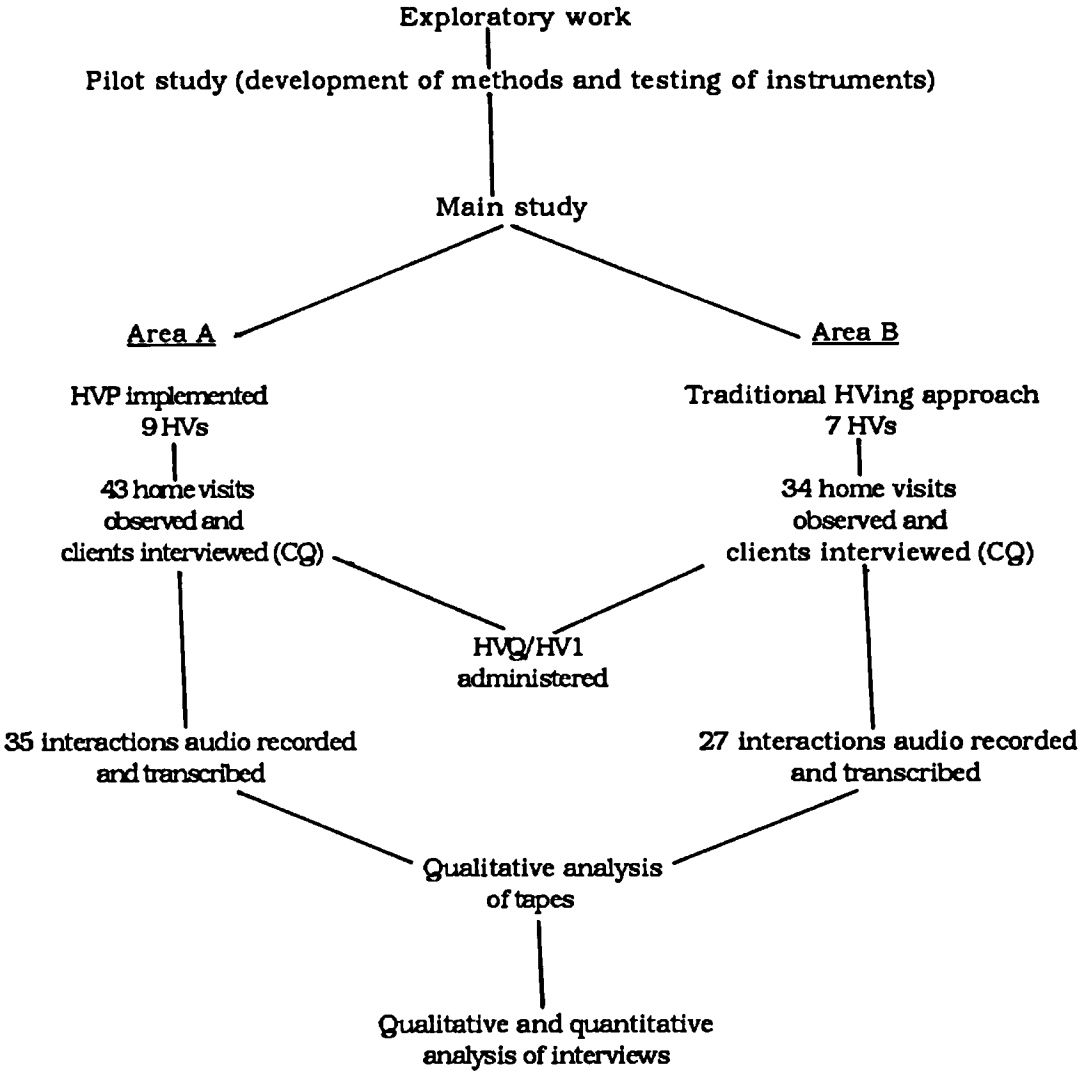
The study design is shown in figure 1. Following exploratory work and a pilot study to test the research instruments and feasibility of the method, the main study was conducted.

A comparative approach was taken to the study of two District Health Authorities, one using the Health Visiting Process (HVP) designated Area A, and the other using traditional methods of health visiting - Area B.

Nine health visitors from area A were involved and 41 home visits were observed and recorded. In Area B seven health visitors were involved and 34 visits were observed and recorded. Whilst interview data were collected from all 75 of these clients, only 62 tapes were suitable for analysis as described later in this chapter.

The samples of health visitors and clients were convenience samples and were not matched in any way. This was felt to be appropriate as the aim was not to compare like with like on an individual basis, but to compare "ordinary" Health Visiting Practice from two districts using different approaches to the organisation of their care.

Figure 1.Design of the study



Exploratory work

Before the methods described could be designed and tailored to meet the requirements of the study, some exploratory work was carried out with an existing data-base of audio recorded health visitor-client talk (DHSS, 1978-1980). The purpose of this exploration was to elucidate the nature of the health visitor-client interaction, to develop the research aims and to test the feasibility of using data of this nature for the proposed study.

A considerable amount of time was spent listening to and transcribing these tapes. However, as an existing data set several problems were presented. The tapes were firstly of very poor quality and presented difficulties in interpretation as much of the dialogue was missing. Additionally, very few were transcribed. The tapes were poorly organised, others uncoded and undated which meant that problems of context and inference were present. Finally, access was restricted which meant that the current researcher could not spend as much time as was initially planned on this work.

Despite these problems, this exploratory work inspired the current researcher to collect a new, audible set of data which would be more up-to-date and without the contextual difficulties presented by completely anonymous data. It also clarified the suggestion from the literature that health visitors and clients interactions need further exploration, description and explanation, particularly in the light of current thinking on client-centered care. Therefore, although unsatisfactory in many respects, the exploratory work did help in the development of the research questions and aims. Questions raised included:

> To what extent is the client participative in the interaction?
>
> What processes does the health visitor use to encourage client participation?
>
> Is the client's participation in an interaction reflected in how she perceives a home visit?
>
> Does the HVP have any effect on these processes?

These questions, it was felt, could be feasibly addressed by an analysis of audio-recorded health visitor-client interactions, by observing the interactions and by interviewing HVs and clients.

The Pilot Study

The aim of the pilot study was primarily to develop and test the methods and approach. This process included assessing the feasibility of using audio-recording as a data collection method and the logistics and feasibility of the researcher acting as an observer. Additionally, the initial design of the interview schedules were tested in the pilot study for their comprehensibility to both clients and health visitors and for their validity.

Sample and Access

For the purposes of the pilot study data collection instruments were tested in one health authority. The health authority selected was a central London location where, in fact, the health visiting process had been implemented over a two year period. The pilot study was conducted between December 1986 and March 1987.

The sample for this stage of the study consisted of two health visitors, each of whom visited three clients giving a total of 6 clients. Access to the sample was sought via senior health visiting management and the District Ethical Committee. In the case of the health visiting manager a letter explaining the study was followed up by a personal meeting between the researcher and the manager. The manager was willing for two health visitors in her area to take part in the study but felt that she should be selective about the participants. This inevitably meant that the two health visitors taking part in the study had been asked by their manager to do so and thus there was little sense of volition on their part. This was countered to a large extent by meeting with the health visitors and explaining the nature of the study to them. It is difficult to assess how much difference this made to their contribution to the study but it was a process which

was revised for the main study to ensure that health visitors had more say in whether they took part in the research or not.

The District Ethical Committee took rather longer to reach a decision on whether or not the study could take place within the health authority. One interesting regulation for the researcher as a nurse was the insistance of the Committee that the study must be approved by a named Medical Consultant before it could go ahead. This proved difficult to achieve given the nature of the inquiry but was finally approved by a consultant paediatrician. Once this condition was met the study was cleared on ethical grounds, the main concern being informed consent and confidentiality.

Data collectionMethods

Each of the two health visitors in the pilot study were accompanied on three home visits to clients. The clients were selected, *a priori*, by the health visitors who obtained verbal agreement from the clients. It was found that, at least on one occasion, this verbal explanation by the health visitor was not adequate for the client to be fully aware of the nature of the data collection and that a full explanation by the researcher was necessary. This inevitably meant that some of the natural course of the dialogue between health visitor and client was lost whilst the researcher was explaining the study and obtaining written consent from the client. However, it was felt that safeguarding the client's right to withdraw from the study and her right to be reassured on matters of confidentiality, were paramount. Therefore, on arrival the researcher outlined the nature of the inquiry to the clients emphasising confidentiality, need and purpose of the tape recorder and written consent was obtained (Appendix 1).

The interaction between health visitor and client was audio recorded in each visit using the Sony TCM cassette tape recorder and the Minkom radio microphone system. Radio microphone equipment was selected as they are less obtrusive than hand-held microphones and they permit participants to move around freely without fear of

falling over cables or disconnecting from the tape recorder. They also provide high quality sound reproduction in conjunction with a professional recorder. The radiomicrophone was fitted to the health visitor prior to the visit and switched on once consent from the client had been obtained. The proximity of health visitor and client did not necessitate the wearing of a microphone by the client. Although stereo sound reproduction would have been helpful for the purposes of transcribing, it was felt that this small advantage to the researcher was less important than respect for the client's dignity. Observation by the researcher was carried out by placing herself in a suitably unobtrusive position in the room, out of direct eye contact with either health visitor or client. On one occasion this became a very difficult position due to the number of family members present on the visit in a very small room. Thus, whilst the researcher maintained a non-participative approach towards the main protagonists it was inevitable that the father, grandmother and uncle tried to draw the researcher into the conversation. According to Simmel (1964) and as discussed by Kratz (1975) once an interaction involves more than three participants it will tend to have triadic rather than dyadic qualities which changes the dynamics of the interaction. Thus, it was felt by the researcher that it was less disruptive if she withheld from participating in this type of encounter.

Interviewing of the clients and health visitors took place after the visits. The pilot interview schedule consisted of some open questions and, in an attempt to measure perceptions, a Likert-type scale was also employed. Whilst the open questions were satisfactory, the Likert-type of questions were found to be invalid as the clients did not fully understand them and they did not provide the depth of response required by the researcher.

Liaison over the interviews was found to be crucial during the pilot study. Initially, it was planned that the client interviews would be carried out on a return visit to clients at the end of the day and health visitor interviews to be carried out when all visits were

completed. In practice, several problems arose with this process. Some clients were not available at the end of the day and therefore the interview was post-poned until later in the week. In such cases the researcher felt that the client had more difficulty recalling the content of the home visit. Similarly, although it was originally hoped that all three visits would be completed in a day this also did not happen in practice so that the health visitor interviews referring to earlier visits required more recall on the part of the health visitors than the later visits. It was therefore decided, for the purposes of the main study that this process should be altered so that all interviews were completed as soon as possible after a visit.

Findings of the Pilot Study

The 6 transcripts from the pilot study were transcribed verbatim. These data were not analysed in detail as the purpose of the pilot study was to test the feasibility of the method rather than to analyse results. This preliminary work gave the researcher the opportunity to develop skills in transcription and to make some initial observations on the content and process of the health visitor-client interaction. The observations formed the basis of the analytical framework developed in the main study and will be discussed in detail in the context of the main study data collection and analysis process.

The interview data were examined in terms of content and validity. Whilst the open questions were apparently representative of the reality observed, the Likert scale questions did not appear to be meaningful to the clients and therefore had little face or content validity; the purpose being to address their perceptions of the visit. The pilot study therefore provided a valuable experience from which additions and changes to the main study could be made.

Major revisions

As a result of the pilot study the following revisions were made to the design and method of the main study. Health visitors were fully involved in the decision to take part in the study. The interview schedules were adapted so that all questions which were related to health visitors' and clients' perceptions of a visit were open (See Appendices 3 and 4). These were subsequently tested on one health visitor and one client before embarking on the main study which suggested that the schedules had more face and construct validity. The timing of the interview was adapted so that interview data were collected from clients immediately following a visit rather than at the end of the day or later in the week. Interview material was collected from health visitors at the end of a session of visits, that is at the end of a morning or afternoon.

In conclusion, the pilot study indicated that the overall method was feasible and that, with some adaptations, was capable of producing reliable and valid data. The main study therefore proceeded.

The Main Study

Following the pilot study, the revisions suggested were implemented so that the main study could proceed.

Access

In order for the main study to fulfill the overall aims of the research it was necessary to include at least two District Health Authorities (DHA) in the study so that comparative data could be collected from health visitors using the HVP and those using traditional methods.

The first two health authorities which were approached declined to take part in the study. This rejection was in both cases brought about by health visitor managers. In one case, the manager felt the health visitors could not take on the extra commitment of being involved with research, whilst in the other it was felt that the current study would conflict with research already taking place in the health authority. Thus, these two applications did not proceed to the District Ethical Committees.

The next DHA approached, via the manager for health visiting, proved to be more successful. This area, designated area A, had implemented the Health Visiting Process three years previously. Geographically, it was a North London suburb consisting mainly of urban communities. Following written correspondence a meeting was arranged between the researcher and the health visitor manager and other senior health visitors. At this meeting the researcher was able to describe the inquiry and explain its significance in terms of the development of health visiting practice and at the same time gather important information about health visiting in the DHA. It was established that:

> The HVP was in progress and had been implemented three years previously.
>
> Implementation of the HVP had followed consultation between managers and practitioners.

A working party had been established to develop the implementation process.

Study days had been offered to health visitors.

New records had been developed in response to the perceived changes in practice required by implementation of HVP.

Whilst the principles of HVP generally had been adopted there was no apparent philosophy of care which guided implementation. However, the managers agreed that, in general, health visitors had accepted the change.

Following this consultation, it was agreed that the researcher should meet with all the health visitors within the DHA to discuss the research and the implication for those potentially taking part. This took place at the quarterly meeting of all health visitors where the researcher was able to answer initial questions. This, it was felt, was in line with changes suggested by the pilot study in that health visitors felt involved from the beginning. At the end of this meeting, a request was made for volunteers to come forward to their managers. Initially, it was hoped that ten health visitors would be willing to take part. The pilot study had confirmed that the nature of the inquiry demanded that health visitors should take part voluntarily. A third meeting then took place with the nine health visitors who volunteered to participate. This proved to be a lively meeting where the researcher was able to inform the health visitors fully of the implications for them of participating, demonstrate recording equipment and obtain written consent from all those making the decision to take part. The main concerns were confidentiality and anxiety about the presence of the tape recorder. Reassurances were offered on both levels. It should be emphasised that whilst the overall theme of the study was discussed with the health visitors and the methods fully described, the detailed aims were not discussed as it was felt that this knowledge could possibly distort the data. At the end of the meeting all nine health visitors consented to take part. Concurrent with these meetings an application was made to the District Ethical Committee for the research take place within the DHA. The study was cleared

on ethical grounds in May 1987, the chairman taking the view that formal application of nursing research studies was unnecessary.

The next DHA approached followed a similar process. This DHA, designated area B, was situated on the outskirts of North London and included some semi-rural populations as well as more built up communities. A similar series of meetings with health visitor managers and health visitors was set up as for Area A. The result of these meetings was that seven health visitors agreed to take part in the study.

The health visitors in Area B were not using the HVP and were following what may be described as "traditional" methods of health visiting practice. Traditional practice is difficult to define as it may encompass a range of approaches developed by individual health visitors. It is perhaps easier to define what it is <u>not</u>:

Traditional practice is not carried out according to an officially adopted and implemented philosophy of care; such as HVP.

Traditional practice does not therefore follow any defined structure.

Traditional practice does not require the formation of a specific record card , although records are, of course, maintained.

Loosely, traditional practice may be seen as health visitors working within a structure dominated by home visiting and child health clinics in which parameters and priorities are defined by the paradigm of child health. This then was the perceived context of the practice of health visiting in Area B.

The application for Ethical Clearance in Area B was more protracted than Area A as the committee required the attendence of the researcher at their meeting which was held quarterly. The Committee were reassured on grounds of confidentiality of the tapes and informed consent at the meeting in May 1987 and official clearance was given in July 1987.

Sample of health visitors

As indicated, the sample of health visitors from each area was drawn on a voluntary basis from the total number of health visitors working in each district. It is accepted that the voluntary nature of selection could have incurred a sampling bias in that those health visitors willing to participate are likely to be those more interested in research and matters related to practice. However, the study was not designed to be representative of all health visiting and caution is exercised in making generalisations from the data. This type of sampling has been described by Field and Morse (1985) as opportunistic sampling:

> "Informants are selected according to the quality of their relationship with the researcher and their ability to articulate and to provide explanations for the researcher."

It is appropriate for an essentially qualitative study to utilise this approach as reaching an understanding of the data was more important than testing hypotheses and establishing causal relationships. Using this approach 9 health visitors were selected from area A and 7 health visitors from area B.

Sample of clients

Similarly, when it came to selecting clients for the study the opportunistic approach was adopted. In this case, as in the pilot study, the initial approach to clients was made by the respective health visitor. It was felt that the health visitors were most likely to have a relationship with their clients which would offer some guidance for selection. The researcher, however, suggested to the health visitors the following selection criteria:

> Clients should be seen on a home visit which is not the primary visit to a first or subsequent baby.
>
> Clients should have at least one child under one year.
>
> The visit under study should be part of the health visitors "routine" visiting and not a crisis-intervention visit or a visit to a family with exceptional problems.

The justification for these criteria were as follows. It was felt that it was important to explore what happens in the health visitor-client interaction in the period following the primary visit. At least two other studies (Sefi 1985 and Montgomery-Robinson 1987) have concentrated on the first visit and it was hoped that this study would provide a further dimension to the understanding of interactional processes between health visitors and mothers. It could be that the primary visit is atypical since for many mothers it is the first time they have met their health visitor whilst subsequent visits form part of the realtionship-building process. It was also seen to be important that the visits under study were recorded during a period when the health visitors interaction with a family is likely to be at its most active - during the first year of a child's life. Between one and five years home visiting tends to become less frequent and the relationship between health visitor and client may therefore change accordingly.

It was emphasised that "routine" visits should form the focus of the study since it was anticipated that visits to families with overwhelming problems would be ethically difficult for the researcher as observer to be present at and also the interaction would be likely to be very different to that which occurs during a "routine" visit. A "routine" visit may be loosely defined as one where the health visitor is visiting to either advise on or assess an aspect of child development or family health which she would universally do for all members of her caseload. It was recognised, however, that the nature of a routine visit can easily be disrupted by the emergence of unanticipated problems. It was suggested that, under these conditions, the health visitors select five families each for the purposes of the study. It was felt that by observing each health visitor with five different families a reasonable cross-sectional data base would be obtained.

Table1 shows the total numbers of health visitors and clients from each area and the distribution of families between health visitors.

Table 1. Samples of health visitors and clients from Areas A and B

Area A (HVP)		Area B (Traditional)	
HV Code	No. of Clients selected	HV Code	No. of Clients selected
1	5	X1	5
2	5	X2	5
3	5	X3	5
4	5	X4	5
5	5	X5	4
6	3	X6	5
7	5	X7	5
8	5		
9	5		
Total No. 9	41	7	34

Of a potential 80 clients, 75 clients were visited and interviewed. Not all tape recordings were completely successful so that a total of 62 recordings were available for analysis. The reasons for this are discussed below. Where five families were not visited, this was due to sickness in the case of HV A6 and lack of time for HV BX5.

Consent of clients

As discussed in the pilot study, it was essential to obtain full written consent from the clients before tape recording commenced. Thus on arrival at the client's home, the health visitor introduced the researcher and the researcher proceeded to explain the broad nature of the study, the need to audio-record the conversation and the request to interview the client following the visit. Full assurances of confidentiality were given and all clients approached consented, in writing, to take part in the study. Whilst this process disrupted, to some extent, the flow of interaction between health visitor and client it was, nevertheless, seen to be an important procedure given that the researcher could not rely on the health visitors initial explanation to the client being sufficient to warrant informed consent.

Data collection

Data collection in Area A commenced in June 1987 followed by data collection in Area B. As in the pilot study, each health visitor was accompanied by the researcher on visits to the selected clients. Following obtaining consent from the client, the tape recording equipment was turned on and the researcher positioned herself in an unobtrusive corner of the room. No changes were made to the type of equipment used. The equipment was not turned off until the health visitor and client had reached the natural end of their interaction. At this point, the health visitor normally left the house, leaving the researcher to interview the client privately. This meant that clients did not feel inhibited in their responses to the researcher and also that the researcher could ask the client about her perceptions of the visit whilst it was fresh in the client's mind. Health visitors normally waited outside in the car for the researcher, taking the opportunity to write up records etc. None expressed any dissatisfaction with this arrangement.

The semi-structured interview (Appendix 4.) comprised totally of open questions. Whilst some of these addressed demographic details of the families, the majority were concerned with how the client perceived the visit in terms of:

The health visitors purpose in visiting.

The client"s expectations of the visit.

Needs or problems.

Planning to meet needs.

Participation in the plan.

Follow up.

Overall role of the health visitor.

The semi-structured nature of the interview (CQ) schedule enabled the researcher to work through these areas, with prompting, in 20-30 minutes. By the end of a morning or afternoon session two to three visits were generally completed following this procedure. At this point, the health visitor was interviewed (HVQ), within the same terms, about her perceptions of the visits just completed.

Following completion of all planned visits, the health visitors completed the health visitor interview (HVI) which explored their perceptions of aspects of health visitor practice (Appendix 5). This interview was more detailed and took 30-45 minutes to complete, normally within the confines of the health visitor's office.

Problems associated with data collection

There were two main problems encountered during the data collection period for the main study.

1. Problems with recording equipment

As indicated previously, out of a total of 75 visits only 62 recordings were adequate for transcription. There were several reasons why recordings were either incomplete or inaudible. The main reason was failure of batteries - this could be either in the tape recorder itself or in the radio-transmitter used with the microphone. Whilst the researcher carried some batteries and tried to maintain a check on the power, it was not appropriate to start changing batteries half way through an interaction. This meant that the researcher had to become alert and adept at changing batteries between visits and carrying out regular maintenance checks on the equipment. Another minor cause of equipment failure was interference with the radio-microphone by small children or pets which was managed as far as possible at the time but again, it was not always appropriate for the researcher to interject. Occasionally, the radio-microphone became dislodged when the health visitor was involved in some activity -

carrying out a developmental assessment with a baby for example. In these cases, the microphone could normally be re-positioned without too much interference.

2. Problems with interviewing

The problem with interviewing clients was mainly an ethical one for the researcher.

On at least two occasions the researcher was given personal information about the client which they had not shared with the health visitor. One particular example had important health implications for the whole family - the mother had had a positive blood test for a sexually transmitted disease which she assumed she must have contracted from her husband but had not discussed with him. She had not been aware that she could discuss this type of problem with the health visitor, believing her role to be solely related to the well-being of the baby. She sought advice from the researcher. This posed a dilemma for the researcher as she was not visiting the family in the capacity of health adviser and therefore questioned whether she should give advice or counsel the mother. Additionally, the information provided was relevant to the health of the whole family and there was a question of whether it be passed on to the health visitor.

As the researcher was not involved with the family, other than as a researcher, it was decided that advice should be witheld which might conflict with advice which may be given at some future time by either the family doctor or health visitor. The mother was, however, urged to discuss the matter with both her GP and health visitor. As the information was given in confidence, the mother was assured that her problem would not be discussed outside the house with other health professionals but that she could approach her health visitor if she wanted to discuss it further. The mother appeared satisfied that the health visitor's role had been explained to her but the researcher was left in the unsatisfactory position of leaving the mother with her problem and not

knowing whether she was ever able to discuss it further. It was felt, however, that the position taken by the researcher was the right one in these circumstances.

Sometimes, clients wanted to discuss the perceived shortcomings of their individual health visitor with the researcher. Although this was perhaps a problem for the client, ethically the researcher did not consider it her role to pass on such information to either the health visitor or her manager. The problems, where they existed, were usually to do with personality conflict or misunderstanding of the health visitors role and in such cases the researcher maintained a position of objectivity and respected that the information was given in confidence. Had the information been of a more serious nature, for example, accusations of negligent practice or criminal activity, then the dilemma would have been more difficult to resolve and the researcher would have had to have considered the costs and benefits of confidentiality over the common good. Dilemmas of such a serious nature did not, however, arise.

Analysis of the data

Interview data

The client questionnaire (CQ) and health visitor questionnaire (HVQ) were analysed quantitatively as the aim of this part of the analysis was to reach a measure of agreement between client's and health visitor's perceptions of a visit and also to provide some descriptive statistics about their respective perceptions. It was postulated that this approach to analysis would triangulate with the transcript data thereby enhancing the validity of the data. The nature of the design of the semi-structured interview meant that detailed coding had to be carried out before the data could be used. However, the nature of the responses meant that descriptive statistical material could be backed up with example commentary which adds both validity and interest to the material.

Coding

There were 75 completed interview schedules - 43 from Area A and 35 from Area B. This material included 75 CQ's and 75 HVQ's, each schedule relating to one visit. Thus, there was a total of 150 schedules to be coded. This was done manually. A coding frame was drawn up by the researcher based on the framework of the overall design of the schedules. This included demographic data followed by the major HVP categories. Codes were formulated to represent the common themes and categories which emerged from the interviews under each section. For example, under the broad category "Purpose/objectives of health visitor's visit" a common response was associated with checking the baby's health so a code was assigned to the category "checking/assessing the baby's health". This was further broken down into "baby's general health" and "developmental assessment". Where atypical responses occurred a category "other" was assigned. The code frame was found to reliably represent the data when checked by two other nurse researchers. Using a random sample of 10 interviews, 85% inter-code reliability was achieved. The interviews were all coded and the coded data entered into the computer.

The Statistical Package for Social Sciences (SPSS, Inc. 1983) was used to produce frequencies and statistics. The chi-square test of statistical significance was employed where appropriate. However, it was recognised that, because of the way in which the sample was drawn (i.e. an opportunitistic sample) that the findings could not be generalised. Since the CQ and HVQ were coded in exactly the same way for most items it was possible to use the computer to analyse the percentage agreement between pairs of HVs and clients for those items in the schedules for which it was deemed appropriate. These included:

Perceived objectives/purpose of visit.

Perception of needs/problems.

Perception of plan of action.

Perception of follow up.

Although the findings from this analysis can only be related to the current study, it was seen to be an important aspect of triangulation because congruence or non-congruence on these items could validate findings from the relevant transcript data. Additionally, the analysis offered the opportunity to explore the construct of client participation in terms of percentage agreement, the assumption being that the higher the agreement the more negotiated the encounter. Also, comparisons could be made between the two areas. The findings from these analyses are presented in Chapter six and discussed in Chapter eight.

Analysis of the Interactions

The study of verbal interaction is one which has been addressed by researchers in sociology and anthropolgy since the early 1950's. Interest in the field amongst nurse researchers has grown and developed during the last decade although one notable early study (Johnson and Hardin 1962) laid much of the original ground work.

Whilst methods of collecting the data have been refined from observation and note-taking (Kratz 1975) to more sophisticated technical methods involving audio and video recording (Chalmers 1987, Macleod-Clark et al 1987), the analysis of the data remains a complex process where no one analytical method has been shown to be either directly appropriate to nursing or more reliable than another. Several approaches have been taken, the most relevant of which will be described here, but most nurse researchers have found that the process of analysing interactions has to be adapted to the context of the study.

Interpretations of the term "interaction" appear to vary. Some analyses (Byrne and Long 1976, Baldock and Prior 1981) concentrate on the verbal contribution of one participant only - in the studies cited the professional talk is analysed with little reference to the client contribution. Whilst this approach has enlarged the body of

knowledge on professional talk, it is debateable whether it can be described as interaction analysis. The Oxford English Dictionary (1964, 5th ed.) defines the verb to interact as "to act reciprocally, to act on each other". An analysis of this action must then take into account the contribution of both parties since the verbal behaviour of one will be reciprocated by, or at least influenced, by the other. To describe how professionals talk to clients in isolation from how clients respond and influence the professional's next response is a rather one-sided approach to the analysis which may even distort the reality of the event. For example, Baldock and Prior (1981) have described social work talk as a skilled interaction. This analysis has been criticised by Clifton (1981) for failing to define what skilled interviewing means and making ambiguous statements in terms of the interviewer being "skilled" and the client being "confused". This ambiguity in the analysis could have arisen from the fact that the authors:

> "did not attempt a detailed analysis of the way the client conversed" (Baldock & Prior 1981 : 22)

They therefore presented little data and no analysis of how the social workers talk could be interpreted as skilled in the light of the client's verbal behaviour. Similarly, some researchers have interpreted interaction analysis as an analysis of content rather than process. Johnson and Hardin's (1962, 1964) two part report on home visits by public health nurses describes the approach used in analysis. This approach is heavily quantitative with emphasis on topic, content, time, number of questions asked by the nurse etc. The authors allocate only three categories to patient verbal behaviour (total household verbal output, percent household verbal output in response to questions and percent verbal output given to residual statements) compared with eight categories for verbal behaviour by the nurse. As discussed in chapter two, the study was valuable for the contribution it made in bringing the methods into the domain of nursing. However, the lack of analysis on process renders the analytical method inappropriate to the current study where the aim was to understand more about the

client's participation in the interaction and the processes and techniques employed by health visitors and clients in determining responses from each other.

Other, more recent research, has attempted to redress the dichotomy between content and process. Tucketet al (1982) for example, analysed 405 interviews between doctors and their patients. One of the main issues under investigation was:

> "The part played by patients in the consultation and the extent to which they were able to influence them".
> (Tucket et al 1982 : 3)

Whilst the analytical technique in this study remains largely quantitative in approach, the researchers define clear categories for both doctors and patients which help to explain aspects of verbal behaviour between them. For example, one category identified in terms of doctor-talk is giving justification for an action, whilst a category identified under patient-talk is requesting justification. The researchers were able to demonstrate that where patients requested justification doctors were likely to provide a more elaborate explanation of their action than if this information was not overtly requested. Without reference to the patient's contribution to the interaction, these more elaborate explanations might have been misinterpreted.

Whilst the categories identified in Tucketet al (1982) work are not all directly appropriate to health visiting (e.g. presentation of symptoms) the principle of defining categories directly concerned with the client's verbal behaviour was seen to be significant in terms of client participation.

Other research studies in the nursing domain have also emphasised process rather than content. Macleod-Clark (1982), for example, extensively reviewed available analytical methods for studying human verbal interaction and found that none of those previously reported (such as Bales 1950, Byrne and Long 1976) were either sensitive enough or reliable enough to apply to the analysis of discourse between nurses and patients in the surgical setting. Macleod-Clark (1982) therefore devised her own

framework for analysis based on communication skills. Through the analysis of over 300 interactions between nurses and patients she was able to identify the processes which occur in such interactions and the techniques and strategies that nurses use to either involve patients in conversation or block them. Thus, for example, not only was Macleod-Clark able to show that nurses ask more questions than patients, but also that the type of question asked (open, closed, leading etc.) could predict the patient's response. This approach to analysis was continued in a later study of nurses' health education interactions (Macleod-Clark, Haverty and Kendall 1987). Again, by analysing the units of interaction (the "turn") in terms of communication skills it was postulated in this study that outcomes in terms of smoking behaviour could actually be affected by the process of the interaction. Both these studies have important implications for the current study. Since verbal interaction is the main resource available to the health visitor, skills in communication are clearly in the interests of developing the health visitor-client relationship. Equally, as has been discussed, health education is a major aspect of the health visitor's role and therefore an analysis of health visitor-client interaction would necessarily take into account this preventative approach which most other analyses do not consider. However, it was felt that to understand the nature of the health visitor-client interaction in terms of client participation an analysis which encompassed more than the communication skills involved should be employed. As Clark (1985) has pointed out, the Gestalt principle operates in any verbal interaction so that the whole construction is more than its constituent parts. Thus, whilst it was recognised that the type of questions and other skills used by a health visitor have important implications for client participation it was also felt to be important to understand more about the holistic nature of the encounter.

Some other studies specific to health visiting have addressed the issue of analysing interactions. Clark (1985) in her study of the process of health visiting also found that previously tried techniques of anlaysis were not sensitive enough to the nuances of health visiting. Clark, in fact, abandoned attempts to quantify her interaction data as she found that intercoder reliability using the framework she devised based on topics and skills was less than 60%. Clark suggested that the major cause of this problem was the lack of a theoretical framework in health visiting on which to base the category system. Clark then went on to use her data in an attempt to develop a theory of health visiting. The interactions were analysed using a grounded theory approach (Glaser and Strauss 1967). The problems in relation to Clark's study have been outlined earlier in chapter two. In summary, however, Clark's claims for her substantive theory of health visiting based on interaction analysis must be viewed with caution because she did not adhere to the basic tenets of the grounded theory approach as proposed by Glaser and Strauss (1967).

Thus, whilst Clark draws attention to the problems of analysis in the health visitor-client interaction her own approach was not seen as being appropriate, methodologically, to the current study.

Two further studies which have contributed significantly to the understanding of health visitor-client talk are those of Sefi (1985) and Montgomery-Robinson (1987). Both of these studies have drawn upon the school of ethnomethodology (Garfinkel 1967) and more specifically on the field of conversation analysis which has grown from it (Sacks, Schegloff and Jefferson 1974).
Whilst, as discussed earlier, this study drew eclectically from a variety of social research methodologies, it has drawn more heavily on ethnomethodology and in particular conversation analysis for the analytic framework of the health visitor-client interaction.

Ethnomethodology has been described by Benson and Hughes (1983) as "an examination of unanalysed and undescribed social knowledge". The approach aims, they suggest, to:

> "examine the ordinary, common-sense, mundane world in which members live and do so in a way that remains faithful to the methods, procedures, practices etc., that members themselves use in constructing and making sense of this social world".
> (Benson and Hughes 1983 : 30)

The analysis of conversation is clearly one way in which the researcher can explore and develop an understanding of the social world of the participants. Indeed, as Heritage (1984) points out, conversation is perhaps the major resource that people have at their disposal to enable them to both construct and make sense of the social world. The originators of conversation analysis (Sacks, Schegloff and Jefferson 1974) were interested in everyday conversation and developed the technique around a data base of audio-recorded telephone conversations.

Esssentially, conversation analysis is concerned with describing the procedures and expectations in terms of which speakers produce their own behaviour and interpret the behaviour of others.
The principle of 'symmetry', as proposed by Garfinkel (1967), is applied so that account must be taken of both the production of verbal behaviour and its interpretation.

Heritage (1984) has suggested that the most fundamental assumption of conversation analysis is that:

> "all aspects of social action and interaction can be found to exhibit organized patterns of stable, identifiable structural features."
> (Heritage 1984 : 241)

Speakers bring to the conversation knowledge of these organisations which influences their own behaviour and their interpretation of the behaviour of others. This is seen by conversation analysts as a "competence". Conversation can therefore be analysed to exhibit these organised patterns of action and the competencies which underlie

social activity. Heritage (1984) has also suggested that the nature of conversation is both context-shaped and context-renewing. Thus, in the analysis of conversation it cannot be isolated from its context. Conversation is:

> "context renewing in that each action in forming a new context to which the next will respond, will inevitably contribute to the sequence of actions within which the next will be formed and understood" (Heritage 1984 : 280)

Thus, in conversation analysis, contributions from both participants must be equally considered.

Heritage (1984) additionally proposed that no order of detail in interaction can be dismissed, *a priori*, as insignificant. This infers that, not only are details such as pauses important in the analysis, but that premature theory construction must be avoided. Analysis is therefore strongly data-driven, developed from phenomena which are evidenced in the interaction data.

> "Correspondingly, there is a strong bias against *a priori* speculation about the orientations and motives of speakers and in favour of detailed examination of conversationalists actual actions". (Heritage, 1984 : 243)

A further aspect of conversation analysis is to reinforce the assumption that conversation is structured in a regular way which is understood by the participants by demonstrating the 'deviant case' where such structural organisation is not present.

The primary approach to conversation analysis is the concentration on action sequences and turns within sequences as the unit of analysis.

> "Conversation analysis is (therefore) primarily concerned with the ways in which utterancy accomplish particular actions by virtue of their placement and participation within sequences of actions". (Heritage 1984 : 245)

This emphasis on sequence is based on the notion that a current turn will project a relevant next activity or range of activities to be accomplished by other speakers in the next turn, a simple example of this would be the exchange of greetings. Such an example is termed a "paired action" and the overall phenomenon has been referred to by Schegloff and Sacks (1973) as "sequential implicativeness". Whilst, it is not claimed by Heritage or others that paired actions such as greetings exchange or question/answer *always* occur adjacently, it is suggested that participants *expect* it to occur and that absence of an immediate response to a question, for example, will lead to an attempt by the speaker to account in some way for its absence. Thus, the questionner may persist or repeat his utterance. It is this type of structure in the conversation which interests the analyst as it begins to provide some explanation for the way in which conversation is organised.

More recently, interest has grown in the organisation of institutionalised talk (e.g. school rooms, court rooms) and the domain of health visiting falls into this category. Therefore one question that the analyst of institutionalised conversation must be aware of is, does the conversation differ in any way from ordinary, "mundane" conversation? This question has been addressed by Sefi (1985) and by Montgomery-Robinson (1987) in relation to health visiting encounters. Both these studies found that the health visitor-client conversation does have features which differentiate it from everyday conversation. For example, Sefi (1985) was able to demonstrate that question asking and advice giving by health visitors tended to cast the mothers in the role of uninformed recipient of information which Heritage (1984) has suggested is a technique by which an institutionalised context may be inferred. In ordinary conversation questions do not tend to possess this "exam-like" characteristic. Sefi (1985) also identified the "third turn sequence" in which health visitors tended to respond with a comment following a question/answer paired action.

Montgomery-Robinson (1987) suggested that mundane conversation could not adequately account for the extended turn taking that she observed in her analysis. This referred to lengthy explanations by health visitors and long accounts by clients. These brief examples from previous studies serve to illustrate the detailed analytical properties that this field of analysis possesses. Thus, analytical methods which overlook the contribution of both participants could not be considered appropriate for a study of client participation whilst a method such as conversation analysis was seen to be more sensitive to the aims of the study.

The principles and ideas of conversation analysis have been drawn upon in this study. However, it does not claim to be an "ethnomethodological" study neither are any claims made about furthering the method of conversation analysis. The primary purpose of the study was to describe and develop understanding of the client's participation in the health visitor-client interaction and the principles of conversation analysis have been built into the analytical framework in order to meet this aim. To this end, the researcher has not used the detailed transcription notation which is common to conversation analysts as it was felt that this distracted from understanding the practice of health visiting. Similarly, whilst some of the constructs developed by conversation analysts such as sequences and "turn taking" are referred to, not all have been applied to this analysis.

In summary, several approaches to analysing verbal interactions have been considered and use has been made of the extensive reviews of previous researchers (notably Macleod-Clark 1982 and Clark 1985) in this respect. Analytical methods which do not take equal account of both participants (such as that used by Bales 1950, Byrne and Long 1976, Baldock and Prior 1981) were discarded as not being sensitive to the aims of this study. Other methods such as those used by Macleod-Clark (1982) and Tuckett et al (1982) were seen to be relevant to this study as they concentrate more on process. The main approach drawn upon, however, was that of conversation analysis (Sacks, Schegloff and Jefferson 1974) which has been developed by Heritage (1984) as it was felt

it would be sensitive to the need to look at verbal contributions from both participants and had particular value in the attention to detail which would enable the researcher to analyse the data as a holistic entity rather than broken down into rigidly pre-defined categories.

The Analytical Process

In order to apply the principles of conversation analysis described above, the audio-tapes were transcribed verbatim including nuances such as pauses, laughter and conversational subtleties such as "um" and "er". However, pauses were not timed and detailed transcription notation was not employed. The unit of analysis was the sequence. A sequence was defined as a piece of dialogue within the interaction as a whole, of variable length which had a recognisable beginning and end. Thus, for a example, a sequence may consist simply of an exchange of greeting or may be a much more complex sequence of assessment. Within each sequence the "turn" was analysed for its contribution and significance to that sequence, the turn being defined as a single uninterrupted utterence by either participant.

Following transcription the interactions were duplicated and examined in detail for sequences in conversation which revealed patterns and themes which illuminated the way in which health visitors and clients interact. It was hoped that categories would emerge which would enlighten the researcher on the ways in which clients participate in the process on health visiting and the extent to which practicing within the HVP framework encouraged this. Coding of the data was carried out by a process of colour coding. This involved highlighting sequences as they emerged with a particular colour so that similar sequencing patterns could be easily identified both within and bewtween interactions. Sequences varied in length from one turn each to as many as 12 turns each and were identified by changes in style or content.

Field and Morse (1985) suggest that more than ten major categories in the initial phase of analysis is unmanageable. Thus, four major categories were identified in this study and thereafter the 'rule of parsimony' was followed which permits sub-categories to be derived from the larger domains whilst maintaining a manageable analysis. Whilst it was tempting to impose an analytical framework upon the data derived from the stages of the Health Visiting Process, it was recognised that the emphasis on conversation analysis is that it should be data driven. Thus, it was accepted that by imposing

categories such as "assessment" and "planning" would constrain the analysis and bias the findings. Therefore, using the colour coding approach, the four major categories which emerged were:

setting the agenda

gathering and providing information

giving and receiving advice

closures

Within these four domains a number of sub categories were identified which are displayed in Table 2.

These four domains reflected the symmetrical nature of conversation as suggested by Heritage (1984) and also the effect of sequential implicativeness but as will be discussed in detail in chapter seven, the dominance of the health visitor in the conversations was a recurrent theme, which tended to undermine the concept of client participation.

Table 2.

Analysis of interactions: Categories and subcategories

Category	Subcategories
Agenda setting	Broad question Specific question Evaluative question Statement of health visitor function Goal related statement Use of the child Client initiated agenda
Gathering and providing information	Questions and answers Questions, answers and commentary Making observations
Giving and receiving advice	Solicited advice Unsolicited advice Use of the child
Closures	Closing topics Controlled openings Making a date

In brief, whilst every effort was made to identify the clients' contributions to the interactions, the subcategories which emerged were largely determined by the controlling nature of the health visitors' contributions. This issue is addressed in chapters seven and eight.

Findings from the Interview Data

This chapter addresses the findings from the interviews with health visitors and clients. These included the interviews pertaining to the health visitors' perceptions about aspects of health visiting practice (HVI), the health visitors' perceptions of the visit (HVQ) and the clients' perceptions of the visit (CQ).

The Health Visitor Interview (HVI)

The Health Visitor Interview (HVI, appendix 5) was delivered to all16 health visitors in the study.

The HVI consisted of 22 items which sought both demographic information and information related to the health visitor's perceptions and feelings towards the Health Visiting Process (HVP), the concept of participation and other practice related concepts. Thirteen of the 22 items were open ended.

Characteristics of the Health Visitors

As a group , the 16 health visitors were fairly homogenous. The mean age was 44.75 years with a range 28-58 years. They were all women and 15 out of 16 were white. There was one Asian health visitor. The majority (12) were married with children. The number of years qualified as a health visitor ranged from 2 - 30 years with a mean of 12.5 years. Almost half (7) were qualified Field Work Teachers and most had additional qualifications to the basic RGN/RHV which ranged from midwifery through to orthopeadic nursing. None were educated to degree level. Fifteen worked on attachment with a General Practice and 13 worked a geographical "patch" within this. Caseload size in terms of children under five years ranged from 152-500 with a mean of 284. The lower caseloads were managed by the two health visitors who worked part-time.

Table 3 gives a summary of health visitor characteristics for the whole group, broken down into the HVP group and non-HVP group.

Table 3. Characteristics of health visitors in the study

	ALL n=16	HVP n=9	non- HVP n=7
Age yrs			
Range	28-58	33-58	28-53
Mean	4475	44	45.5
Marital Status	12 married	6 married	6 married
Qualifications			
FWT	7	3	4
SCM	6	3	3
Other	13	6	7
Yrs qualified	8 wks - 30 yrs	4 - 30 yrs	8 wks - 22 yrs
mean	125	135	11.2 yrs
Yrs in current DHA	8 wks - 17 yrs	0.8 - 17 yrs	8 wks - 14 yrs
Mean	7 yrs	8 yrs	6 yrs
GP attached	16	9	7
Geographic	13	8	5
Base: Clinic	10	9	1
Surgery	5	0	5
Health Centre	1	0	1
Full-time	14	8	6
Part-time	2	1	1
Caseload < 5 yrs			
Range	150-500	150-450	152-500
Mean	284	233	342
No. fixed sessions/wk.			
Range	1-6	1-3.25	1-6
Mean	26	22	2.8

There were two clear differences between the HVP and non-HVP group. One was their practice-base. All the HVP group were based in District Health Authorities (DHA) clinics whilst most of the non-HVP group were based in doctor's surgeries. This could have implications for their responses to their perceptions of the HVP since health visitors working in clinics are more likely to be in daily contact with colleagues and therefore have access to peer group discussion. Health visitor's based in surgeries are often isolated from health visitor colleagues and perhaps do not have similar opportunities for discussion of professional developments on a day-to-day basis.

The other noticeable difference between the groups was the higher mean caseload size in the non-HVP group (342 compared to 233 in the HVP group). This could have implications for the way practice is organised and prioritised, which would influence the way in which practice is perceived and explained by the health visitors.

Otherwise, the two groups are remarkably similar in their characteristics and experience of health visiting so that any differences in their perceptions of practice might be explained, in part, by the use (or not) of the Health Visiting Process.

Health Visitors' Perceptions of the Health Visiting Process (HVP)

A qualitative approach was taken for this aspect of the study. This was considered to be appropriate as it was important to explore in some depth what the health visitor's actually understood by HVP and where appropriate how they experienced it. This enabled an interpretative approach to be taken to the analysis in relation both to how Health Visitors understand and experience the process of health visiting and also how they perceive the underlying concepts such as enabling and participation.

Thus, the following account of the health visitor's perceptions of the HVP is based on the semi-structured interview which formed part of the HVQ. All the questions raised

by the interviewer were open-ended and prompting was used to encourage expansion of views and ideas.

In order to facilitate comparison, this description of the findings is divided into two parts - one of the views of the health visitor's from the HVP area and one of the views from the health visitor's working in the non-HVP area.

HVP Health Visitors

Nine health visitors from this area completed the HVI.

In Service Training for HVP

The HVP had been implemented into practice three years prior to the commencement of the study. One aspect of implementing a change in practice is to offer staff some form of in-service training both so that they may become familiar with new ways of practicing and new responsibilities and also so that they have an opportunity to ask questions and challenge accepted ideas and assumptions. The degree and level of training the nine health visitors in the HVP group had had varied considerably. Some had been involved on the steering committee which was set up to implement the scheme and others had taken part in the pilot scheme. There were four health visitors who had been part of a committee and they seemed to interpret this experience in several ways. Firstly, it was seen as an appropriate position from which to train other health visitors about the HVP. As one health visitor said:

> "I was involved in the steering committee. One day was allocated for each health visitor which involved someone from the steering comittee going right through the record card and going through case studies."

There was little indication as to where the knowledge and philosophical framework used by the steering committee came from.

Others felt that their early experience with implementation was barely enough to prepare them:

> "I was one of the health visitors in the pilot study. After that we had two study days involving quite a few speakers. It might not have been enough if I hadn't been on the pilot study".

In this health visitors experience, being involved in the pilot study was an adjunct to her training which other health visitors would not have had.

Training among the remaining health visitors was patchy. One thought she had had two study days but couldn't remember any detail about them. Others spoke of meetings, speakers and sessions on how to use the new record cards. Some had had no training at all - in two cases this was because they were new to the district but they had not been offered any orientation training. One commented that she was finding it "a difficult adjustment".

What came through quite clearly was that preparation from this change in health visiting practice had been, at best, sketchy. Not one health visitor was able to give a clear account of her preparation and it was obvious that very little attention had been given to the theoretical considerations for changing practice methods. Indeed, the main consideration appears, from the health visitors recollections of their training, to have been the formulation and completion of the new record card. It is recognised that this interpretation of the HVP relies on the health visitor's memory of events and that direct observation of training may have yielded different information. However, it was neither practicable to observe training which took place three years earlier nor in one sense was it relevant. The health visitor's had made their own interpretation of the preparation and this was how they were translating it into practice at the time of the study.

Perceived effect of HVP on practice

The health visitor's were asked to describe how using the HVP had affected their practice. What emerged was that the health visitor's interpretation of the term "practice" was limited. Pratice appears to have been viewed by the health visitor's as *what* they did and not *how* they did it and many of the comments were thus related to the effect of HVP on activities such as record keeping. One view was that introducing the HVP had not changed practice at all:

> "It hasn't really had an effect - I've always worked with aims and objectives"

Another health visitor commented:

> "It hadn't changed the way I work but it's useful when covering for each other and with students".

This feeling that nothing had really changed appeared to be related to the underlying notion that the HVP was an exercise in record management. A new record system had been introduced which was seen as intregal to the HVP Thus, the value of the HVP in changing the way records were written up could be recognised but little value was placed on it as a theoretical framework for health visiting practice:

> "It makes it clearer, especially if you're away sick"
>
> "It's easier for colleagues to pick up"
>
> "It (the record) makes you more concise and definite about each visit by relating it more precisely to objectives and it's useful for students."

This effect of the HVP is not to be undervalued as it demonstrates an interest in monitoring continuity of care, communicating with colleagues and teaching but it apparently lacks any deeper analysis on the part of the health visitors. One subject showed signs of thinking it through more holistically:

> "It makes you plan your visits better, you think of the family as whole and make your plans for the family."

Although this health visitor was able to relate the concept of holism and individualise family care to the HVP she found it difficult to say how her visits were "better" and resorted eventually to the way she wrote her records:

"You can see at a glance what's been done and what needs to be done."

The fact that health visitors in this study relied heavily on the introduction of new record keeping system as a basis for their understanding of HVP is not to be condemned as the preparation the health visitors had experienced had been fragmentary. There was little reason to expect them to see HVP as very much more than a change in record management as even the literature they were likely to be exposed to has placed an emphasis on the way records are designed and written. (Clark 1982, Rogers 1982, Clark 1985).

Health Visitors understanding of HVP

The meaning that the health visitors assigned to HVP was, not suprisingly, very similar to the way they interpreted it's effect on practice. That is, not only did they use it as way of managing their record keeping but this was generally what it meant to them.

For example, when asked to describe how they understood the HVP, health visitor's gave comments such as the following:

"It's a way of structured record keeping"

"It's a different way of writing down what I do"

"It's a way of recording and using the record to assess and evaluate my work"

These comments reflect the dominant theme in their responses to the question . A few responses touched on themes which potentially could be used to enhance practice:

"It's to encourage parent participation and the way it is recorded so that you have clear objectives from the next visit. It's an aide memoire."

Although this health visitor apparently understood the HVP to some extent in terms of client participation she still implemented it in terms of the record card.

Another view was that it enabled health visitors to define their role more readily and thereby make themselves more accessible to the families:

> "I think health visitors are insecure about their role. The HVP helps them to clarify it."

This health visitor appeared to see her "role" in terms of objectives and outcomes which could be measured by the use of the record card:

> "The advantage is that the health visitor may remember her objectives, it reminds you of the things you have forgotten - such as the reason for the next visit".

Again the health visitors cannot be blamed for the way in which they understand the HVP.

It seems highly probable that this reflects the way in which the HVP was introduced in the DHA and the way in which it has largely been publicised. However, if this was solely the case then one might reasonably expect the non-HVP group to to share some of these views. In fact, as discussed below, the nature of their understanding of the HVP contrasted sharply with that of the HVP group.

Advantages and Disadvantages of the HVP

The health visitors were asked to describe how they perceived the advantages and disadvantges of the HVP in terms of the experiences of both the practitioner and the client.

The HVP health visitors tended to see all the advantages for practice in relation to maintaining a structured record. The advantages put forward were all valid but again there was little recognition of how developing client-centered, individualised approach to care might actually have a beneficial effect on the health visitor-client relationship or enhance client participation. This, it may be assumed, was because the health visitors had not experienced using the HVP in this way. Thus the responses were very similar to those in the previous section:

"It's useful in a relief situation - it's quick and easy to identify objectives. It is also an advantage in a court situation as they are contemporaneously written"

"The advantages are limited - it reminds you of the things you have forgotten. It's an aide memoire".

"The advantage is for colleagues to pick up information"

"It's a teaching tool for students."

Even the responses which were not a direct comment on the usefulness of the record card carry the implication that it was writing it down that had the advantage:

"It keeps your visits on a professional basis and reminds you why you are visiting"

Whilst seeing some advantage in maintaining a structured record, paradoxically it was this activity which also created negative feelings about the HVP:

"It creates more paperwork and is therefore very time consuming".

"My clerical work has increased"

"I don't like the way it has been designed, for example "outcome of objectives" reiterates "present situation" (refers to headings on the record card,)

"Time- there's more writing to do. You have to think very carefully about how you write it. It takes more space."

This use of time was not seen as an investment for the development of their relationship in any way, as one health visitor put it:

"The time spent writing records could be spent talking to the client."

In terms of the impact that the HVP might have on clients the health visitors generally perceived that a structured and well maintained record card could help the health visitor to elucidate the client's needs.

"The client will realise the aim of your visit, will be able to pick up more of the family issues which could give you a broader outlook."

"It makes it easier to see the client's needs. Objectives are clear if the record is up to date."

"It's easier for them to see what the plans are if they want to see the record."

The possibility of sharing records with clients also arose. Althought it was against DHA policy at least one health visitor contravened this and took her records into the home. Generally, however, there was ambivalence about whether records should be shared based largely on the health visitors concern about "problem families" . The main concern was that in families with a child abuse problem, for instance, there were ethical considerations about sharing records. The implication was that families with problems should not participate to the degree that "normal" families do.
In general, the health visitors saw very few disadvantages for the client by implementing the HVP apart from spending time on writing that could be spent talking as already mentioned. There was some feeling that the client wouldn't be aware of any difference anyway and one health visitor commented that the client might not like the idea of records being kept.

In summary, the health visitors from the HVP area saw advantages for clarity, continuity of care and communicating with colleagues through the newly introduced recording system but felt the time spent on completing these records was not well spent. They felt that the clients benefited from the system through elucidation of their needs which could be enhanced by record sharing in some cases and saw very few disadvantages for their clients.

Non-HVP Health Visitors

Understanding of HVP

The health visitors in the non-HVP group were using what might be termed "traditional" Health Visiting approaches in that no form of structured health visiting or process of health visiting had been introduced. They were, however, familiar with the ideas and terminology of HVP through their training and reading of the subject. They were also asked to describe how they understood the HVP. In contrast to the HVP group there was very little reference to record management.

Although HVP was understood as a method of structuring practice it was also seen as way of changing practice towards a more collaborative approach with families:

> "It's a structured, more formal approach to each visit with goals clearly set and evaluated"
>
> "It's a more structured way of health visiting - the health visitor has to consider the purpose of her visit and plan more"
>
> "It's working out together the needs of the family - making plans and seeing if they work on the next visit."
>
> "It means to share your health care plans with the family, to set goals as the client sees them, checking that they have understood"

This group of health visitors, then, appeared to think more in terms of practice development than maintaining records. Practice was discussed in terms of the health visitor - client relationship not just in terms of activities. It is interesting that this group who had not, officially, been "exposed" to the HVP appeared to hold more ideologically appropriate perceptions of it's meaning. One can only speculate on the reasons for this but it seems likely that the health visitors who had experienced the change, interpreted the HVP in the way it had been introduced to them and most importantly through the way it had been operationalised as a record keeping strategy. There is no reason to suppose that their views before the introduction of HVP would have been any different from those of the non-HVP group as the two groups were similar both in education and experience. The possibility arises that the interpretation and operationalisation of HVP offered by management is accepted by health visitors and pre-existing ideals are subsumed. However, there can be no

certainty placed on this assumption without evidence from a longitudinal study which measures change over time. However, such speculations are further supported when the health visitors perceptions of the advantages and disadvantages of using the HVP are examined.

Advantages and Disadvantages of the HVP

The health visitors in the non-HVP area also perceived the benefits on practice to be related to records maintainance:

> "The paperwork helps you to structure your thinking"
>
> "There is an ability for colleagues to be immediately "au fait" with your plans".

However, this reference to record keeping was not so marked as in the HVP group and was consistent with the more ideological meaning that these health visitors ascribed to the HVP. There was reference to client participation, for example:

> "It's a way of involving clients in their care which leads to a better understanding of the health visitor's role"

and to other aspects of practice:

> "It makes you more structured - visits (currently) are not always purposeful"
>
> "It makes the health visitor question her work".
>
> "It provides clarity of thought for future direction".

Clearly, these health visitors were not actually experiencing these advantages and so they could only speculate on what they thought the advantages *might* be. Similarly, although the non-HVP group could see possible disadvantages for practice in relation to record keeping:-

> "Its a lot of paperwork. More than I do now."
>
> "Its a long-winded way of record keeping although I can see the advantage of detailed records".

They also seemed to have more analytical ideas about the negative aspects of changing practice methods:

> "I think it would be more difficult to operationalise in an area with social problems because priorities change so rapidly."
>
> "It might be difficult where there are families of concern because they may not tell you what you need to know."
>
> "It would be difficult with clients who don't have a lot of insight into their needs."

Since the HVP group did not raise these types of difficulties, perhaps it can be assumed that in their experience they did not arise. Alternatively, pre-occupation with the problems of clerical work may have obscured any of the more important issues related to practice. It is interesting that although the non-HVP health visitors perceived advantages in clarification of the health visitor's role and function, they held sceptical views on elucidating the needs of particular client groups - primarly the disadvantaged. It was not clear whether these health visitors felt that their present mode of practice was adequate for this purpose and that therefore the introduction of HVP would in fact be detrimental.

As far as direct benefits to the client were concerned, the non-HVP health visitors generally saw these in terms of the client being able to recognise her needs and understand the role of the health visitor more clearly:

> "The client can perceive the purpose of the visit and can look at the objectives too"
>
> "There would be an awareness of their own needs and how the health visitor could help."
>
> "health visiting might be more easily understood"

These comments carried the implication that clients are not currently fully aware of the health visitors role or of their own needs and that the introduction of a structured, more problem orientated approach to practice could change this. Although these comments were hypothetical, they were generally supported by the health visitors from area A who were experienced in using the HVP. This suggests that there may be

potential advantages to the client in employing an approach to practice such as HVP over the use of traditional approaches.

There was, again, very little which was seen to be disadvantageous to the client in using the HVP. The comments that were offered were interesting since they again carry implications for current modes of practice:

> "Some clients might find it threatening, they might feel they are being checked up on."
>
> "The practitioner might be *too* structured in her aims and objectives - you need to be flexible."

It suggests that traditional methods are non-threatening and flexible whereas previous evidence has suggested that clients do feel threatened by the health visitor (Ashley 1987, McIntosh 1986) and that health visitors can be quite inflexible (Sefi 1985).

Summary

To summarise, the health visitors in the non-HVP area took a more analytical approach to their perceptions of the possible advantages of using the HVP and were less pre-occupied with the role of the record card. It must be taken into account that these ideas were hypothetical, but in one area they were supported by the actual experience of the health visitors in the HVP group, namely the perceived advantages of HVP for the clients. It was generally agreed that clients needs could be more readily recognised and that the health visitor's role might become clearer to the client. The validity of these hypothetical arguments lies in the implications they carry for "traditional" practice methods. This is discussed in further analysis of the clients interviews and the transcript data elucidates this. Although (brief) reference was made by both groups to the possible effects HVP could have on client participation this was not an area which was either emphasised or elaborated on by any of the health visitors. It was felt that there was some recognition of this as a central concept of health visiting practice but the health visitors tended to step warily around the idea of clients sharing records, for

example. Such findings are interesting in the light of health visitor's views about the concepts of enabling and participation.

Health Visitors Perceptions of Enabling and Participation

The concepts of enabling and participation can be seen as central to a framework for practice which expounds an individualised, holistic approach to care. They are, however, concepts which can be interpreted in a number of ways and the health visitors were asked to explore the meanings they ascribed to these terms and whether using HVP had any impact on their interpretation.

Enabling

The way in which both groups of health visitors perceived the concept of enabling essentially fell into three main categories - these included ideas such as self-help, decision making and human potential. A further category also emerged from the HVP health visitors' responses which was involved with delivery of services.

Self-help

Health visitors from both areas felt that enabling meant a process of helping people to help themselves. This was expressed in a variety of ways but essentially implied that enabling was the process of ensuring individual responsibility for health:

"It's to encourage them to help themselves" (HVP)

"I think it's to give suggestions to help them to help themselves" (HVP)

"It's to facilitate the client to identify their own health needs" (non HVP)

This category of views assumed that individuals can help themselves given the right nudge in the proper direction from health visitors. These views would support those underlying current policy documents outlining the future care of people in the community (DOH, 1990). There was no indication of self help being recognised among groups or on a community basis and there was no acknowledgement that self-help might be precluded by a client's social circumstances for example. However, this self-

help approach to enabling accepted that the client is an active seeker of health not a passive recipient.

Decision-making

Enabling was also seen as process of helping people to make decisions. Like "self-help', this was accepted was the right and proper thing for the health visitor to be doing. There was very little analysis of what making decisions actually involves - it was mainly seen in terms of giving information which will widen the choices available to people:

> "It's helping people decide for themselves" (non HVP)
>
> "It's to do with helping them to select what they want to do, giving them a choice and encouraging them" (non-HVP)
>
> "It's to try and get them to realise what they want and help them to achieve it." (HVP)

There was little expansion on what offering people choices means in terms of selection and prioritisation although one health visitor went further towards exploring the options:

> "It's helping them to understand *why* things are done so that the choice is theirs" (non-HVP)

There was very little sense that the health visitors would push people towards a particular choice so that enabling as a decision making process also included acceptance on the part of the health visitor of a client's decision, and support even if the decision was not the "right" one.

Human Potential

Health Visitors from both groups explained enabling in terms of the development of human potential. In this sense the health visitor was seen as a kind of guru and the client as someone in need of guidance:

> "It's enlightening them, helping them to see a purpose" (non-HVP)
>
> "I see it as allowing families to function at a level where people grow" (HVP)
>
> "It's a partnership to work out how people can reach their potential" (HVP)

It was not made clear what these potentialities and purposes are, but whatever it's definition, some of the health visitors clearly felt that this was an aspect of their role. Enabling in this rather abstract context also felt very remote from practice - how can human potential be evaluated, for example? What are the criteria for assessing whether someone has reached their potential or not?

These questions were not adressed by the health visitors immediately but observation and recording of practice provided the opportunity to explore the extent to which the health visitors brought this concept into their practice (chapter seven).

Use of services

Some health visitors in the HVP group described enabling as a process of encouraging clients to use the services available to them. This very practical perception of enabling contrasted the more abstract idea of developing human potential. It was interesting that only the HVP health visitors suggested this as an explanation of enabling, although the reasons for this were not immediately obvious:

> "It's promotion and information re: the services available".
>
> "It' s encouraging the uptake of services ... being a health care salesperson."

This view of enabling seemed to adopt the position of the health visitor as provider of information and services which client's are encouraged to accept. It takes a different view to the "self-help" perception in that the health visitor is perceived as the provider

or helper and the client as the passive accepter or non-accepter of the HV's help. The self-help view sees the client in an active role which the health visitor encourages.

Summary

Given the range of perceptions that this group of health visitors held in relation to the concept of enabling it would be appropriate to propose that a continuum of enabling behaviour could exist ranging from the health visitor as active helper to client as active self-helper:

Figure 2. A Contiuum of Enabling Behaviour

HV PROVIDER/HELPER _____ENABLING_____ CLIENT AS
CLIENT AS PASSIVE RECEIVER ^ ACTIVE SELF-HELPER
^ HV AS FACILITATOR
Decision making
Realisation of potentials

Somewhere along the continuum the client becomes an active decision maker and potententialities are realised. If such a continuum of behaviour exists, the question arises, how is this demonstrated in practice? The skills that a health visitor would need in order to interact with a client along this continuum were not brought out in the HV's comments. Despite prompts and encouragement, they were very loath to say anything about *how* enabling is put into practice and chose to describe *what* it meant to them. Interestingly, nobody chose to describe enabling as a process of "empowerment". Indeed, there was very little sense of relinquishing control completely or recognition of the client as expert as Tucket et al (1985) have proposed. Even the "self-helpers" really saw the health visitor as the central propagator of self-help. This was illustrated by the use of words such as the heath visitor "gives", "allows", "helps" and so on which suggest that the client is dependent on the health visitor at both ends of the continuum.

This is further illustrated by the ways in which the health visitors described "participation".

Health visitors understanding of participation

Conceptually, it can be understood that in order to "enable" or "empower" a person or group a dynamic process of interaction must exist between two or more actors which creates a relationship of mutual respect and sharing of knowledge and ideas. Each actor is thus an active participant in the relationship (Tucketet al, 1985). In a practice situation such as health visiting participation might involve a process of reaching a mutual understanding of needs, for example, or an acceptance by the health visitor that the client has knowledge and expertise from which the health visitor can learn. The health visitors in this study were asked to describe what participation meant to them. Overall, they were positive about the concept - it was recognised as something that should be encouraged and promoted in health visiting. However, health visitors from both areas appeared to perceive participation as an ideological rather than a reality-based concept:

> "it's something always to aim for, but it's easy in theory." (HVP)
>
> "Ideally, it is essential" (non-HVP)

Others hinted that whilst participation might not be a feature of health visiting *now* it would exist in some future world of health visiting and clients:

> "I'm all for it - I think they (the clients) should" (HVP)
>
> "I would encourage it, I think it is very important" (HVP)

Some were able to offer more explanation as to why they felt particiaption would be valuable:

> "It is everything, unless the client wants to do something nothing can be done" (HVP)
>
> "Clients should be aware of their own health needs" (non-HVP)
>
> "Clients have freedom of choice but they need knowledge on which to base their choice. Hopefully, health visitors can provide the knowlege" (non-HVP)

In some cases actual examples of participation as the health visitors saw it were cited:

> "I think it's a good idea in most cases, for example I have put the onus for making appointments onto parents" (non-HVP)
>
> "It is necessary - for example, giving parents information about immunisation so they can make an informed decision". (non-HVP)

Despite being generally receptive to the idea of participation some health visitors did have reservations which seemed to relate to the way they categorised their clients. For example, participation was seen as being dependent on the client's intellect or emotional development:

> "It really depends on the client's motivation. It's easier to implement if the client is articulate."
>
> "Ideally, it's essential but the physical and emotional development of the client doesn't always allow it."

In the same way that some health visitors had reservations about sharing records with certain disadvantaged groups of clients this same qualification was set against participation in some cases. This seems to imply that using a participatory approach for clients of a similar social standing and maturity as the health visitors was acceptable whilst less privleged groups could not cope with making their own decisions, for example. This hints of a form of social prejudice which allows the health visitor to retain control over certain client groups which could have worrrying implications for the practice of health visiting. It certainly raises some questions about the way in which health visitors arrive at criteria for assessing who can participate or who cannot.

To summarise, the concept of participation was widely accepted. Health visitors tended to describe their understanding of it in ideological terms although some were able to suggest examples of participation in practice. However, participation was not always viewed as a universal approach to health visiting as some health visitors felt that it might not be appropriate for certain disadvantaged clients to participate in their care.

Characteristics of the clients

Data were collected from 75 clients which related to their age, occupation of both partners where appropriate, number of children and age of childen. Ethnicity was also noted. Characteristically, the clients formed a reasonably homogenous group. In most cases the mother only was seen in the home but on five occasions the father was also present and in several cases other persons were present (e.g grandmother, friend).

The clients ranged in age from 20 - 50 years. The upper range age was that of one person - a grandmother who had sole care of the infant. The modal range was 25 - 30 years. The number and ages of children in the family was seen as significant as this could have a bearing on the client's perceptions of the health visitor. Previous studies have suggested that the value of the health visitor is mainly recognised by mothers in the early months of a child's life (Orr 1980, MacIntosh 1986). A mother with previous child care experience or who has found other sources of support and advice may perceive her own needs differently to the novice mother.
Similarly, this could influence how the health visitor perceives the mother's needs. The number of children per family ranged from 1 to 3 and the mode (56%) was 1 child. The ages of the youngest child ranged from 10 days to 2 years and the modal range was 4 - 8 months (36%). Socio-economic group of the mothers was assessed by occupation of both parents according to the Registrar General's classification. It was thought to be important to look at the occupation of both parents where appropriate as where these differ, different attitudes and values may be held.

Table 4 shows the socio-economic groups of both parents where appropriate for the total sample:

Table 4. Socio-economic status of parents

S/E group	Father	Mother
1	12 (16.0%)	3 (4.0%)
2	28 (37.3%)	18 (24.0%)
3	2 (2.7%)	22 (29.3%)
4	20 (26.7%)	6 (8.0%)
5	1 (1.3%)	0 (0.0%)
Unemployed	2 (2.7%)	4 (5.3%)
Self-employed	2 (2.7%)	2 (2.7%)
None given	8 (10.7%)	20 (26.7%)
Total	75 (100%)	75 (100%)

Mother's occupation was based on their previous employment if they were not working because of motherhood. Fifteen (20%) had returned to work or were completing maternity leave.

Unemployment was low and it was generally more likely that the women did semi-professional or "white collar" work than the men who were more likely to hold professional or semi professional positions or do skilled manual work. As a whole, the occupational groups of the clients clustered around social classes two, three and four suggesting a middle to lower class group .

Occupationally, the fathers in the HVP group were more likely to hold semi-professional or managerial (43.9%) positions than the non-process fathers where as many men were likely to be semi-skilled manual workers (29.4%) as semi-professional (29.4%). The women in the HVP group were more likely to be "white collar" workers (34.1%) (e.g. office clerk) than the women in the non-process group who were most likely to be semi-professional (26.4%). Health Visitors are classed as semi-professional and it could be argued that the clients in this study were not likely to be too dissimilar in their attitudes and values to the health visitors visiting them.

The two groups were remarkably similar for mother's age range (25-30 years) and number of children (1). The youngest child in the non-HVP group was likely to be younger by a few weeks than the youngest child in the process group. This small difference would not be expected to alter the mother's perception of the health visitor, however, because of the typical pattern of health visitor contact during the first year of a child's life (Wiseman, 1982).

Ethnically, the total sample was overhelming white (91%) but the health visitors in the HVP group were more likely to encounter Asian women (15%) than those in the non-HVP group(3%). this would be supported by the geographical locations with the HVP area being an outer London suburb whilst the non-HVP area was semi-rural. In summary, the clients encountered on the 75 visits recorded tended to be white and lower middle class with one child in 4 - 8 months age group. The mother tended to be in the 25-30 year age group and was unlikely to be working or returning to work.

Health Visitors' and Clients' perceptions of visits.

In this section of the chapter the findings from the CQ and the HVQ will be presented. The extent to which participation was put into practice is explored in terms of the degree to which health visitors and clients held congruent views on each visit. An assumption was made that the higher the level of congruence, the more participation would have been experienced by the client.

Health Visitors and Clients were interviewed after each visit using semi-structured interview schedules (see appendices 3 and 4) as described in chapter five. A total of 75 pairs of interviews were completed - 41 in the process area and 34 in the non-process area. In addition, further data were collected from the health visitors in relation to their evaluation of the visit and long-term aims and further data from the client in relation to their current needs, expectations and views on the health visiting service generally.

The responses were coded and entered onto the computer for analysis of frequency using SPSSX (SPSS, Inc. 1983). Descriptive, quantitative findings are presented, illustrated with comments from the health visitor or client where appropriate. The chi-square test of statistical significance of difference between two samples was employed as appropriate.

A. Health Visitors and Clients Perceptions of objectives/purpose of the visit

A wide range of objectives of visits were quoted by both clients and health visitors. Most individuals gave more than one response. Table 5 provides a summary of the responses given and the frequencies of the responses from all visits (n = 75), the process visits (n = 41) and the non-process visits (n = 34). The category coded "other" includes items mentioned rarely and includes objectives such as safety, health education, giving information and the research itself.

Table 5. Health Visitor's and Clients' Perecptions of Objectives of a Visit.

OBJECTIVE	Process n=41 pairs				Non-Process n=34 pairs				Both groups n=75 pairs			
	Client		HV		Client		HV		Client		HV	
	n	%	n	%	n	%	n	%	n	%	n	%
Baby's health	14	34.1	2	4.9	10	29.4	1	2.9	24	32.0	3	4.0
Coping	8	19.5	22	53.7	5	14.7	5	14.7	13	17.3	27	36.0
Child Development	7	17.1	27	65.9	10	29.4	16	47.1	17	22.7	43	57.3
Feeding	3	7.3	23	56.1	3	8.8	8	23.5	6	8.0	31	41.3
Weaning	2	4.9	7	17.1	5	14.7	5	14.7	7	9.3	12	16.0
Immunisation	0	0.0	15	36.6	0	0.0	6	17.6	0	0.0	21	28.0
Sleep	1	2.4	5	12.2	1	2.9	2	5.9	2	2.7	7	9.3
Mothers Health	5	12.2	4	9.8	4	11.8	3	8.8	9	12.0	7	9.3
Routine visit	6	14.6	1	2.4	2	5.9	0	0.0	8	10.7	1	1.3
Friendly visit	2	4.9	0	0.0	2	5.9	1	2.9	4	8.0	1	1.3
Weight Measurement	1	2.4	4	9.8	2	5.9	3	8.8	3	4.0	7	9.3
Toddler Assessment	0	0.0	5	12.2	2	5.9	2	5.9	2	2.7	7	9.3
Follow-up	2	4.9	3	7.3	6	17.6	11	32.4	8	10.7	14	18.7
Other	9	22.0	6	14.6	2	5.9	10	29.4	11	24.7	16	21.3

More than one response was possible.

chi-square for all responses = 72.4 13df $p < 0.001$

It is clear from these data that health visitors and clients appear to primarily objectify their encounters within a model of child care and development. Despite the claims of some of the Health Visitors in the HVI that they look at the whole family, the focus of these visits was clearly on the child. Although the mother's health was referred to in 12% of all visits by clients and 9.3% of all visits by Health Visitors, this was a small proportion of the total responses given and very small if compared to a single objective such as "development" where 22.7% of the clients and 57.3% of Health Visitors mentioned it. An initial analysis, then, suggests that both HVs and clients see the purpose of the Health Visitors" visit as being baby-orientated. This would substantiate previous research on the consumer's view of health visiting (Orr 1980, Ashley 1987) and the literature on the Health Visitor's role (Clark 1980, Wiseman 1982).

Another most striking pattern which emerged from these data is that in general, the Health Visitors' stated objectives for their visits were significantly different to the client's perceptions of the purpose of the Health Visitors call.($p<0.001$). For instance, according to the Health Visitors 57.3% of all the visits were for the purpose of carrying out a developmental assessment whilst only 22.7% of the clients mentioned this purpose. Similarly, whilst 28% of all visits were said by the Health Visitors to be for the purpose of discussing immunisation, *not one* client gave this as a rationale for the call. Similar differences can be observed for almost all the items relating to objectives of a visit.

These data appear to suggest that there is little negotiation between Health Visitors and their clients about why the Health Visitor is making a home visit. This important issue is discussed further in chapter eight.

Whilst the Health Visitors listed very specific objectives, the clients were generally more vague in their understanding of the purpose of a visit. This is illustrated by the fact that more clients than Health Visitors were likely to respond that the visit was to look at the baby's general health (32% clients compared to 4% of Health Visitors) and that the visit was "routine" (10.7% of clients, 1.3% Health Visitors). These responses reflect a feeling of uncertainty on the part of the client as to the purpose of the Health Visitors visit:

"I think it was just general".

"I don't know really - probably to check the baby and see how I"m doing".

The explanation for some of this uncertainty could lie with the finding that just under half (48%) of all the clients were not normally given advance notice of a visit. This represented 48% in the HVP group and 52% in the non-HVP group. Many of them did not express any objection to this but nevertheless making proper appointments to visit could enhance negotiation between Health Visitor and client and may lead to a more participatory encounter. The Royal College of Nursing (1982) have endorsed the notion

of visiting by appointment on the basis that "dropping in" represents a kind of social policing. This proposal is supported by a small-scale study conducted by Luke and Joyce (1986) in which an appointment system for home visiting was compared to the effectiveness of visits where a prior appointment was not made. The authors found that ineffective visits were reduced to 3% in the study area compared to 27% in the non-appointment area. However, despite claiming that the results demonstrated the possibilities for client involvement in their care, effectiveness was measured purely on the basis of the health visitor being able to gain entry. The work of Reynolds and Hay (1986) went further towards exploring the value of appointments to clients and they found that 97% of clients interviewed were favourable towards health visitors visiting by appointment, although, interestingly, the health visitors in this study perceived more disadvantages than advantages for an appointment system. The Health Visitors in the current study had described the amount of time wasted on writing records in the HVI. Time invested in making prior appointments with clients would perhaps save time in the long term as less time would need to be spent negotiating the purpose of the Health Visitor's call and wasting time on visits where the client was out. Indeed, Reynolds and Hay (1986) carried out a cost-benefit analysis of the appointment system and found that substantial saving of both time and money were possible. An appointment system also has the potential for allowing the client to think about the visit in advance so that she can prepare questions, plan the visit to suit her own needs, plan for others to be present if necessary and so on.

In the current study, the Health Visitor's objective was often to see how a mother was "coping" or to help her to cope. Over a third (36%) of the visits had some component of this nature according to the Health Visitors whilst only 17.3% of the clients responded that the Health Visitor had visited to find out how they were coping. There could be two explanations for this potentially damaging situation - either Health Visitors were over-labelling mothers as women who couldn't cope, thus undermining their abilities as mothers or the clients were reluctant to admit to the researcher that they couldn't cope so that the real situation was under recorded. In general, the researcher did not

feel that the clients were holding back on their responses but it is accepted that in a 20-30 minute interview there may be uncovered responses.

Differences between HVP and non-HVP responses

A further observation to be made from these data on objectives of a visit is the differences in frequencies of stated objectives between the HVP area and the non-process area. It can be noted from Table 5 that a break down of responses into HVP and non-process areas provides a similar pattern of frequencies to the visits as a whole.

However, there are some differences between the two groups which cast uncertainty on the integrity of the Health Visitors responses to the HVI. It will be recalled that although Health Visitors from the HVP area had largely seen the HVP as a record management tool they had seen its advantages lying in making objectives and planning visits with the family.

What can be seen from these data is that, for some items there were very large discrepencies between the frequency of Health Visitors perception of her objectives and the frequency of the client's perceived purpose in the visit. Considering the two samples together for all items this difference was statistically significant ($p< 0.001$) This is particularly noticeable for the variables coping (HV 53.7%, client 19.5%), development (HV 65.9%, client 17.1%) and feeding (HV 56.1%, client 7.3%). This suggests an absence of negotiation of objectives with the client. For the non-HVP group, discrepencies also exist but are not so wide and in some cases there is apparent agreement. For example, on the variable of coping (HVs 14.7%, clients 14.7%) the frequency of response is the same whilst development (HVs 47.1%, clients 29.4%) and feeding (HVs 23.5%, clients 8.8%) have a narrower differential. It is not possible to predict with any certainty from the data as they have been presented so far whether HVP health visitors are more or less likely to concur with their clients than non-HVP health visitors. These data only give the *frequency* of each response and do not give any real measure of the degree

of congruence between individual Health Visitors and their clients. For example, although the objective of five visits by Health Visitors in the non-process area was to see if the client was coping, there is no way of knowing from these data whether these five visits were related to the five clients who perceived the purpose of the visit in relation to their own coping capacity.

Thus, in order to obtain a more accurate analysis of the level of congruence between pairs of Health Visitors and clients the data were analysed to produce a percentage of agreement on each variable. The fact that the overall differences were significantly different provided the basis for a closer analysis. A summary of these data can be found in Table 6.

Percentage agreement between the clients and health visitors on perceived objectives of visits

The data shown in Table 6 gives the percent agreement for each objective variable between Health Visitors and clients for all visits, HVP visits and non-process visits. The variables displayed are those which were identified by both Health Visitor and client in relations to a particular visit.

The percentage agreement where neither party gave a particular response was found to be higher, but agreement on not responding was felt to be a rather spurious measure of agreement. The reasons for not giving a specific response are manifold - memory, reluctance to discuss with researcher, misinterpretation, misinformation etc. Since it is impossible to judge why a respondent has not given a particular response it was felt that measuring agreement between pairs of positive responses was the only valid way of analysing agreed statements between Health Visitors and clients. Where there is disagreement between pairs of statements it is suggested that the transcript analysis may offer some explanation of this (see chapter seven).

The most striking observation from Table 6 is the low level of agreement between Health Visitors and clients on all the stated perceived objectives, ranging from 1.3% (toddler management) to 20% (developmental assessment). These data suggest that whilst, for example, 43 Health Visitors and 17 clients stated development as a purpose for the Health Visitors visit (Table 5), in only 15 of these cases did the Health Visitor and her client agree. Similarly, whilst 7 clients and 12 HVs perceived discussion of weaning (Table 5) as an objective, only 4 pairs were in agreement. The implication of these data is that Health Visitors and clients do not often share a common view of why the Health Visitor has visited.

Table 6. Objectives of visits: perecentage agreement between health visitors and clients.

OBJECTIVE	Process n-41 pairs		Non-Process n-34 pairs		All visits n-75 pairs	
	n	%	n	%	n	%
Coping	5	12.2	3	8.8	8	10.7
Child Development	7	17.1	8	23.5	15	20.0
Feeding	3	7.3	0	0.0	3	4.0
Weaning	1	2.4	3	8.8	4	5.3
Sleep	1	2.4	1	2.9	2	2.7
Mothers health	2	4.9	0	0.0	2	2.7
Weight Measurement	0	0.0	2	5.9	2	2.7
Toddler Assessment	0	0.0	1	2.9	1	1.3
Follow-up	0	0.0	3	8.8	3	4.0

Clearly, where there is disagreement clients may have questions unanswered or problems unresolved whilst the Health Visitor may feel that she has not achieved her objectives and thereby is frustrated in her work. Whilst visiting by appointment might facilitate some negotiation between a Health Visitor and client over the purpose of a visit, the transcript data illuminate how opportunities to enlarge on her role and purpose are frequently lost by the Health Visitor (see chapter seven).

As can be seen from Table 6 levels of agreement between Health Visitors and clients in the process group and Health Visitors and clients in the non-process group are similar. For both groups the highest level of agreement was on development (17.1% HVP, 23.5% non-HVP) whilst for both groups there are instances of zero agreement.

Interestingly in the HVI, the health visitors had explicitly stated the advantages of the HVP as being able to set clear objectives. From these data it appears that the Health Visitors using the HVP were no more likely to set objectives in negotiation with the client than were the Health Visitors in the non-HVP group.

Again, it seems probable that a lack of prior arrangement of visits in the past in many cases (51% HVP group, 44% non-HVP group) may have contributed to the client's lack of understanding of the purpose of the Health Visitor's call. Despite this, Health Visitors have opportunities to discuss their objectives with clients on arrival and to be open to the client's expectations but as the transcript analysis shows this rarely happened (see Chapter seven). The obvious concern arising from these data is that where Health Visitors are using an approach to their practice based on a problem-solving model (HVP) which demands participation from the client there is very little evidence from these data that the approach is in fact operating in this way.

B.Health visitors and clients perceptions of need

Health Visitors and clients perceptions of need were ascertained through the Questionnaires. Table 7 provides an overall summary of the range of frequency of responses given.

Table 7. Health Visitors' and Clients' Perceptions of Need

NEED	Process n=41 pairs				Non-Process n=34 pairs				Both groups n=75 pairs			
	Client		HV		Client		HV		Client		HV	
	n	%	n	%	n	%	n	%	n	%	n	%
Breast feeding	2	4.9	3	7.3	1	2.9	3	8.8	3	4.0	6	8.0
Medical	6	14.6	8	19.5	7	20.6	4	11.8	13	17.3	12	16.0
Feeding	15	36.6	13	31.7	10	29.4	9	26.5	25	33.3	22	29.3
Sleep	6	14.6	3	7.3	4	11.8	2	5.9	10	13.3	5	6.7
Support	8	19.5	12	29.3	8	23.5	10	29.4	16	21.3	22	29.3
Family relationships	0	0.0	3	7.3	0	0.0	7	20.6	0	0.0	10	13.3
Toddler	2	4.9	6	14.6	1	2.9	4	11.8	3	4.0	10	13.3
Social	1	2.4	4	9.8	1	2.9	5	14.7	2	2.7	9	12.0
Mother's health	3	7.3	6	14.4	3	8.8	4	11.7	6	8.0	10	13.4
Child development	4	9.8	6	14.6	2	5.9	1	2.9	6	8.8	7	9.3
Coping	0	0.0	4	9.8	0	0.0	12	35.3	0	0.0	16	21.3
Nothing	6	14.6	6	14.6	9	26.5	0	0.0	15	20.0	6	8.0
Other	10	22.4	7	17.1	3	8.8	6	17.6	13	17.3	13	17.3

More than one response was possible.

Chi-square for overall responses =43.7 12df $p < 0.001$

In line with the earlier proposition that Health Visitors and clients largely see visits within a developmental, child health model, these data appear to confirm this. The majority of the responses made by Health Visitors referred to needs in relation to child care although interestingly the two needs identified by Health Visitors which fall outside this model - family relationships and mother's health - were rarely cited by the clients. This serves to confirm the suggestion (e.g. Sefi 1985) that clients perceive the health visiting service as a baby-orientated service and this issue is discussed and a case study given in chapter eight to illustrate it. It could be that the clients did in fact have needs in relation to their own health or their family relationships but these were not perceived as relevant in the context of a home visit from the health visitor.

There is a significant difference between the responses given by health visitors and clients for each visit($p < 0.001$). As already indicated, family relationships and mother's health and coping were raerly identified by clients at all whereas health visitors were more likely to perceive a need in relation to the toddler's health (13.3% HVs, 4% clients) and social needs such as housing or finance were also more commonly noted for each visit by health visitors (12%) than clients (2.7%). For some variables of need there was a similar number of responses between health visitor and client's responses than there had been for the same objective variable. For example, feeding needs were suggested by 33.3% of clients and 29.3% of health visitors for each visit which suggests that although the client was not aware that this was part of the purpose of a home visit, she did perceive infant feeding as one of her needs. It also suggests that in some cases health visitors visited with the intention of discussing infant feeding (41.3%) but did not actually perceive this as a need (29.3%). This gives rise to the possibility that not all mother's needs in relation to infant feeding practices were being met, despite the apparent recognition of need between health visitors and clients being close.

The need for support was also identified on a similar number of visits by health visitors (29.3%) and clients (21.3%). Interestingly, the data show that the need for support was perceived as arising from the visit rather than as an objective for visiting. The need for support is closely related to the concept of coping in that somebody who is not coping may need support. However, it appears that from the client's point of view it is more acceptable to need some support than to be seen to be not coping. Perhaps coping has more negative connotations for failure as a mother whereas support can be defined positively as encouragement.

It is interesting to note that in one fifth (20%) of the visits the clients were not aware of any needs at all and this was the case in 8% of the visits reported by health visitors. This apparent non-existence of need could be explained by the client's perception of the

health visitors role or an unwillingness to express her needs to the researcher or by the fact that she does not recognise her needs or simply because she does not perceive herself or her family to have any needs. It is more difficult to explain how a health visitor can visit a person at home for 20-45 minutes and not identify some area of need. This suggests that either there are some cases in which need is genuinely unrecognised by both health visitor and client or that health visitors are failing to recognise and explore need where it in fact exists. Perhaps this is related to how needs are identified and this is illuminated by the transcript data. It may also be explained by the way in which needs are defined. It is accepted that although health visitors appear to share a general understanding of the concept of need in terms of Maslow's (1963) hierarchical model, as illustrated by their explanations of enabling, that there are alternative definitions which explain need in a more problematic way. For example, Thayer (1973) has defined diagnostic need as the identification of a problem. So, for example, if a health visitor or client define a need as a problem they may well not perceive a particular visit as giving rise to a problem. Orr (1985) has argued that Bradshaw's (1972) taxonomy of need can be useful to health visiting practice. Bradshaw differentiated between normative need in which needs are defined in comparison to the perceived norm, expressed need which are peoples articulations or representations of their perceived needs and felt needs. Felt needs, according to Bradshaw, are not always expressed and in such a case need could go unrecognised if they are not elicited by the health visitor.

Differences in perceived needs between HVP and non-HVP visits

A clear variation emerged in the distribution of frequencies of need variables between the HVP and non-process visits. For example, need in non-process visits was more likely to be perceived by health visitors as centred around family relationships (20.6%) than in the HVP area (7.3%) despite the fact that more of the clients perceived the visit in this way. Also, need in the non-process visits was more likely to be perceived by health visitors in terms of coping (35.3%) than in the HVP area (9.8%) whilst need in

terms of development was more likely to be acknowledged in the HVP visits (14.6%) than in the non-process visits (2.9%).

These relatively wide differences in perception of need can perhaps be explained by the orientation of the health visitor. Whilst overall the health visitors appeared to work within a developmental model, it is possible that the health visitors in the non-process area are more relationship centred (in Robinson's (1982) terms) than the process health visitors. In light of the health visitors interpretations of the HVP it seems likely that health visitors in the HVP area are more structured in their approach focusses more on the baby centred problems.

As with objectives, these data about perceptions of need can only reflect the frequency of response and are not a measure of the level of congruence between pairs of health visitors and clients. However, the fact that there was a significant difference overall between health visitors and clients perceptions of need, provided the basis for exploring this in more depth. A further analysis of the data to assess degree of agreement was carried out and the findings are summarised in Table 8.

Percentage agreement between health visitors and clients on perception of need in 75 visits

Table 8 illustrates that, as with the perceived objectives, only the perceived needs mentioned by both health visitor and client have been analysed to produce a percentage agreement.

Table 8. Perceived Needs: Percentage agreement between health visitors and clients

NEED	Process n=41 pairs		Non-Process n=34 pairs		All visits n=75 pairs	
	n	%	n	%	n	%
Baby's medical need	0	0.0	2	5.9	2	2.7
Toddler	2	4.9	0	0.0	2	2.7
Feeding	7	17.1	4	11.8	11	14.7
Sleep	1	2.4	1	2.9	2	2.7
Social	0	0.0	1	2.9	1	1.3
Nothing	1	2.4	0	0.0	3	4.0

When these data are compared with those presented in Table 7 it is obvious that there is a mis-match between the perceived needs stated by health visitors and clients and the degree of agreement between the parties. For example, whilst in 33.3% of all visits, clients perceived infant feeding as a need compared to 29.3% of health visitors, there was only agreement in 14.7% of visits that feeding was a perceived need. Similarly, whilst 21.3% of clients in all visits perceived the need for support compared to 29.3% of health visitors, there was only agreement in 4% of cases. The overall percentage agreement figures are very low which has worrying implications for health visiting practice.

For example, if a client's need for support is not being recognised by the health visitor then clearly she is failing in her responsibility towards the client. Such failing can be seen both in terms of failing to elicit the client's needs as she perceives them and also

failing to respond to needs as they arise, indicating a lack of participation between the two parties. Equally, since health visitors suggested perceived needs (e.g. family relationships) which clients did not perceive as a need the health visitor could be imposing her own agenda of needs onto the situation. This would support the previous suggestion that health visitors visit with their own objectives without prior negotiation with the client. An agenda of objectives would almost inevitably produce an agenda of need as perceived by the health visitor as opposed to the client's perceived needs.

It is also clear from Table 8 that using the HVP is no more likely to increase the percentage agreement on perceived need than not using it. The exception is the need of infant feeding where agreement is slightly higher in the HVP area (17.7%) than in the non-HVP area (11.8%). Overall, this implies that the HVP is not being used as a tool for tailoring care in an individualised and participative way. Certainly it would be reasonable to expect higher levels of congruence if this were the case. Despite health visitors claims that the HVP can promote such care, it appears that opportunities for negotiation and participation with clients concerning their perceptions of their needs have been lost. The transcript analysis provides some explanation of why identification of need was rarely a participative process (see Chapter seven).

C. Health visitors and clients perceptions of plan of action

It has been argued that one way in which the health visitors work can be evaluated is through observation of client outcomes and behaviour change. If it is desirable for the client to behave in such a way as to change the circumstances which would lead to a health need being addressed, then a mutually agreed plan between health visitor and client would facilitate such an action. However, if the plan is perceived or understood differently between the two then the operationalisation of that plan will produce different outcomes which in evaluative terms will define the success or failure of the health visitor's intervention. Even if a plan is mutually acceptable, if it does not

address the real needs as perceived by the client it is unlikely to be put into operation. For example, it is conceivable that the need for developmental assessment could be addressed through an agreed plan for the client to attend the child health clinic. But if the need for transport has not been recognised then the client may not be able to put this plan into action and the health visitor could evaluate this intervention negatively even though the client's intention was positive. The aim of exploring the plan as perceived by health visitors and clients was both to look at the variety of planning activities, the congruence between health visitor and client and the relationship of the plan variable to the need variables.

Table 9 presents a summary of the frequencies for the perceived plans for action. In line with previous discussion, the most noticeable feature is that the plans formulated during the 75 visits as perceived by both health visitors and clients were largely in relation to behavioural goals within a child care orientated model. Thus, plans for infant feeding (41.3%), immunisation (18.7%) and clinic attendance (30.7%) feature highly among the health visitors perceptions and similarly 41.3% of the visits were seen by clients as resulting in an infant feeding plan and 14.7% in clinic attendance.

Table 9. Health Visitors' and clients' perceptions of plan of action

PLAN	Process n=41 pairs				Non-Process n=34 pairs				Both groups n=75 pairs			
	Client		HV		Client		HV		Client		HV	
	n	%	n	%	n	%	n	%	n	%	n	%
Feeding	15	36.6	18	43.9	16	47.1	13	38.2	31	41.3	31	41.3
Sleep	4	9.8	4	9.8	2	5.9	2	5.9	6	8.0	6	8.8
Child Development	2	4.9	3	7.3	5	14.7	10	29.4	7	9.3	13	17.3
Immunisation	5	12.2	8	19.5	2	5.9	6	17.6	7	9.3	14	18.7
Refer to G.P.	0	0.0	6	14.6	1	2.9	5	14.7	1	1.3	11	14.7
Attend clinic	7	17.1	14	34.1	4	11.8	9	26.5	11	14.7	23	30.7
Social	1	2.4	4	9.8	3	8.8	1	2.9	4	5.4	5	6.7
Safety	4	9.8	6	14.6	3	8.8	3	8.8	7	9.3	9	12.0
Give up breast feeding	0	0.0	0	0.0	2	5.9	2	5.9	2	2.7	2	2.7
Re-assess at later date	1	2.4	0	0.0	1	2.4	0	0.0	2	2.7	0	0.0
Continue as at present	3	7.3	4	9.8	3	8.8	2	5.9	6	8.0	6	8.8
Other	11	26.8	9	22.0	10	29.4	5	14.7	21	28.0	14	18.7

More than one response was possible.

Overall Chi-squqre = 17.34 with 11df $p < 0.1$

An interesting aspect of these perceptions of the plan was the emergence of plans which have little or no relation to the perceived needs. An example is immunisation. Immunisation was a perceived objective of 28% of the visits according to health visitors although none of the clients perceived the purpose of the visit in this way. It did not, however, feature as a perceived need for either party as a result of the visit and yet it re-emerges as a plan for action for 18.7% of health visitors and 9.3% of clients. This suggests that the health visitors have organised their visit around a pre-set agenda of objectives which they manage to achieve by the end of the visit even if immunisation is not a client-perceived need. This supports Warner's (1984) work on clinic visits which suggests that health visitors use subtle means for achieving their own goals. This is discussed further in chapters seven and eight.

Attendance at the child health clinic is conceivably an action through which a range of child health needs as perceived by the client could be met. Examples are immunisation, developmental assessment, weighing the baby and the purchase of baby milk and vitamins.

Although it was not always obvious what the precise purpose of such a clinic visit would be or when it would take place, it appears that health visitors (30.7%) were more likely than the clients (14.7%) to perceive a future attendance at the child health clinic as a plan resulting from the visit. Again, the analysis of the process of the formulation of such a plan (Chapter seven) is illuminative in explaining why this difference arises.

Whilst overall diferences between health visitors' and clients perceptions of the plan were not significant, it was seen to be useful to explore the degree of congruence between pairs of health visitors and clients. The analysis of the percentage agreement (Table 10) between health visitors and clients of the ir perceptions of the plan provides further evidence for the health visitors' failure to really address what the needs of the clients were and how these might fit with the planning process.

Perceived plan - percentage agreement between pairs of health visitors and clients

Table 10 illustrates that the degree of congruence between health visitors and clients about the perceived plan is relatively low.

Table 10. Perceived plan: Percentage agreement between health visitors and clients

PLAN	Process n=41 pairs		Non-Process n=34 pairs		All visits n=75 pairs	
	n	%	n	%	n	%
Feeding	8	19.5	9	26.5	17	22.7
Sleep	3	7.3	1	2.9	4	5.3
Attend clinic	2	4.9	1	2.9	3	4.0
Child development	0	0.0	1	2.9	1	1.3
Immunisation	1	2.4	0	0.0	1	1.3
Safety	1	2.4	1	2.9	2	2.7
Social	0	0.0	1	2.9	1	1.3
Continue as at present	1	2.4	0	0.0	1	1.3

For example, there is only 1.3% agreement about immunisation, social action and continue as now ranging to 22.7% agreement about infant feeding. It is interesting that infant feeding is again a point on which there is most agreement. This implies that both health visitors and clients perceive the issue of infant feeding as an objective for the visit, as a need and as something that requires planning more than any other single issue. This suggests that infant feeding is an area in which both parties recognise the health visitors expertise, perhaps facilitating the process of negotiation. However, other areas in which one might expect the health visitor to have expertise such as in the child health clinic and immunisation do not provide such relatively high levels of agreement. For example, agreement on clinic attendance as a perceived plan following the visit was only 4%. This finding may indicate why clinic attendances are often missed - if the client does not perceive the need she is unlikely to take positive action. Such findings may be indicative of a misconception on the clients' part of the health visitors' role and function. Whilst infant welfare in relation to diet and nutrition

appears to be well established as a perceived aspect of the health visitors' role, there appears to be a degree of confusion about other aspects of her expertise. This could arise for a number of reasons but may partly be due to a lack of negotiation between the health visitors and clients about what the health visitors's role is and how needs can be most appropriately identified and met. The process of planning to meet needs is addressed in chapter seven and highlights some inadequacies which may help to explain the descrepencies in congruence.

There are few differences between the HVP group and the non-HVP group on agreement about the perceived plan . Contrary to perceived needs, there is more agreement in the non-process group (26.5%) than in the HVP group (19.5%) over planning for infant feeding. This finding suggests that whilst there was slightly more agreement over the perceived need for infant feeding advice in the HVP group, there was a better chance of an agreed plan on infant feeding being drawn up in the non-HVP group. This implies that whilst some agreement was reached in the HVP group over the need for infant feeding advice, the mismatch which occured when trying to formulate a plan to meet this need could have implications for the evaluation of care. Meaningful evaluation depends on some action being taken towards reaching a mutually defined goal. It appears that evaluation, despite being a crucial component of the HVP, is unlikely to be effective if the action to be taken is not agreed upon. Opportunities for taking a participative approach towards planning care are clearly being missed by both groups of health visitors and this issue is addressed in more detail in chapter seven.

Health visitors and clients perceptions of potential follow-up

A further indicator of the degree of participation between client and health visitor is the negotiation over the need for further contact, the nature of this contact and its frequency. Thus, clients and health visitors were asked how they perceived the follow-up (if any) and the findings are summarised in Table 11.

Table 11. Health Visitors' and clients' perceptions of follow-up.

FOLLOW-UP	Process n=41 pairs				Non-Process n=34 pairs				Both groups n=75 pairs			
	Client		HV		Client		HV		Client		HV	
	n	%	n	%	n	%	n	%	n	%	n	%
Specific date	2	4.9	4	9.8	4	11.8	1	2.9	6	8.0	5	6.7
Within a time period	14	34.1	23	56.1	7	20.6	16	47.1	21	28.0	39	52.0
At clinic	9	22.0	11	26.8	16	47.1	9	26.5	25	33.3	20	26.7
As needed	7	17.1	2	4.9	5	14.7	4	11.8	12	16.0	6	8.0
Routine visits	0	0.0	4	9.8	0	0.0	11	32.4	0	0.0	20	26.7
Regular visits	0	0.0	4	9.8	0	0.0	3	8.8	0	0.0	7	9.3
None	4	9.8	1	2.4	1	2.9	5	14.7	5	6.7	6	8.0
Other	0	0.0	3	7.3	0	0.0	5	14.7	0	0.0	8	10.7

More than one response was possible.

Overall chi-square = 35.45 with 7df $p < 0.001$

As can be observed, there were again significant differences ($p < 0.001$) in health visitors' and clients' perceptions of the potential follow-up. Both clients and health visitors were most likely to perceive the 75 visits concluding in an arrangement to see the health visitor again within a specific period of time (HVs 52%, clients 28%) or at the clinic (HVs 26.7%, clients 33.3%). A small number felt they had agreed on a specific day (HVs 6.7%, clients 8%) and a similarly small number of visits were seen as concluding in no follow-up. Health visitors perceived the follow-up in terms of "routine visiting" in 26.7% of visits, whilst, not surprisingly, none of the clients

suggested this outcome as they could have little conception of what "routine visiting" means. Similarly, and perhaps of more concern, 9.3% of the visits were seen by the health visitor to require "regular visiting", usually for the emotional support of the mother, but the clients did not give any indication of their awareness of this proposed regular visiting. It could be assumed that these visits would be taking place without the client's prior knowledge. The health visitors responses to this section of the interview seem to indicate an interventionist rather than responsive approach and confirm the findings of Foster and Mayall (1990). The health visitors were more likely to see follow up in terms of home visits and within time periods which may or may not be known to the clients, whereas the clients were more likely to cite a clinic contact (33.3%) or a contact as the *client* felt she needed it (16%) both of which strategies would potentially give the client more control over her encounters with the health visitor.

Percentage agreement between health visitors and clients of perceived follow up

The significant differences between the health visitors' and clients' perceptions of follow-up provided the basis for analysing in greater detail the levels of agreement between pairs of health visitors and clients. The percentage agreement between health visitors and clients on the perceived follow up is displayed in Table 12.

Table 12. Perceived follow-up: percentage agreement between health visitors and clients

FOLLOW-UP	Process n=41 pairs		Non-Process n=34 pairs		All visits n=75 pairs	
	n	%	n	%	n	%
Within Specific time period	10	24.4	3	8.8	13	17.3
Clinic	4	9.8	7	20.6	11	14.7
As needed	2	4.9	0	0.0	2	2.7

These data appear to support the earlier suggestion that health visitors and clients did perceive the frequency and nature of follow-up differently. Although there was 17.3%

agreement on all visits that contact would be made between the health visitor and client within a specified period, (which could mean within a week or within 6 months), this was considerably lower than the overall frequency of responses by health visitors (52%) and the clients (28%). Thus, a mismatch exists where health visitors were expecting to resume contact within a certain period with clients who were not aware of this expectation and likewise some clients would be expecting to see the health visitor at a specified time of which the health visitor was not aware. Again, this appears to represent a lack of recognition between health visitor and client about when follow-up should be planned. Similarly, whereas in 33.3% of visits, clients expected to see the health visitor in the child health clinic there was only 14.7% agreement on this response, supporting the proposal that whilst health visitors plan to follow visits up with further home visits clients are more likely to perceive follow-up as an activity which they initiate themselves by visiting the clinic or contacting the health visitor as the need arises.

There does appear to be a higher level of agreement in the HVP group regarding follow-up within a specified period (24.4%) compared to the non-process group (8.8%) and the opposite appears to be true for follow-up in clinic (HVP 9.8%, non-process 20.6%). Possible explanations for these findings are given in chapter eight.

Client's expectations of a visit

As discussed previously clients and health visitors appeared to have differing ideas about the purpose or objectives of a home visit. However, the clients were also asked about what they expected from the visit. Their responses are summarised in Table 13.

Table 13. Clients' Expectations of a visit.

EXPECTATION	Process n=41		Non-Process n=34		All visits n=75	
	n	%	n	%	n	%
Follow-up advice	0	0.0	2	5.9	2	2.7
Reassurance	16	39.0	10	29.4	26	34.6
Developmental assessment	3	7.3	7	20.6	10	13.3
Weaning advice	3	7.3	1	2.9	4	5.3
Feeding/weight advice	4	9.8	6	17.6	10	13.3
Discuss problems	12	29.3	5	14.7	17	22.7
Sleep advice	3	7.3	1	2.9	4	5.3
Immunisation advice	3	7.3	0	0.0	3	4.0
Nothing	5	12.2	7	20.6	12	16.0
Other	8	19.5	8	23.5	16	21.3

More than one response was possible.

Sixteen per cent of all the clients visited claimed that they had no expectations or didn't know what to expect. This is illustrated by some of the responses given:

> "Nothing really. I look on it that they have to check everythings alright."
>
> "I don't know really, I just thought they would examine the baby and check her length etc."

Some of the vagueness that some clients appeared to express in this area may be explained by the fact that almost half (48%) were not normally visited by appointment, thus giving the clients little opportunity to reflect on what they could expect from the health visitor.

Over one third (34.6%) of all clients expressed some expectation of feeling reassured by the visit. Compared to the clients who expressed need for support (21.3%) it appears that some clients expect to be reassured even if they do not perceive themselves as being in particular need of support. Thus, mothers expected to be reassured that what they were doing was acceptable, that their children were progressing satisfactorily and displayed normative developmental and behavioural features. To a large extent these expectations of gaining reassurance sit within a developmental model of child health, there was very little expression of expectations which reflect on the health visitor as an adviser on the social context of child rearing. For example, one mother said:

> "I was waiting to ask about the feeding, I just wanted a pat on the head and be told to go ahead. It's just nice to have her call round."

Another said:

> "Just reassurance about the baby's feeding. It's always nice to be told you're doing well."

Such comments also seem to endorse the view that the health visitor is the child health expert. As Sefi (1985) and While (1985) have identified, the health visitor is perceived as having expert knowledge on child health issues which undermines the expertise of the clients as parents and, according to While (1985), this model takes precedence over a social model of health. Thus, it appears that parents do not perceive themselves to be in

a negotiating position with the health visitor as some of their felt needs do not fall directly into the child health category.

For example, one mother in the non-HVP area who was 41 with a three month old daughter had considerable social problems. Her partner was unemployed and the mother expressed concern to the researcher about managing the heating bills over the winter and buying vital equipment she needed such as a cot. Despite these perceived needs she did not express any expectation that the health visitor would be able to assist in any way. This mother expected "a general chat, to make sure everything is fine" and she saw the purpose of the health visitors visit as "mainly to do with weaning the baby onto solids". Whilst the health visitor in this case recognised that there was a "housing problem" she (the health visitor) also felt that there was nothing a health visitor could do about it.

This brief case study serves to illustrate the apparent lack of ability on the part of the health visitor to translate her appreciation of the social context of health care into action. Her own perceived helplessness appears to have reflected onto the client so that neither side have any real expectation that the health visitor could in any way play a facilitative part in enabling the client to redress these problems. The principles of Health Visiting (CETHV 1977) suggest that the health visitor should "influence the policies affecting health" and "facilitate health enhancing activities" and health visitors certainly have access to resources and information which may be useful to clients. The social context defines the extent to which health enhancing activities can be pursued - if health visitors do not perceive themselves to have the expertise to tackle these issues and clients do not expect it then inequalities in health will not be addressed, either on a one-to-one level or at a local or national policy level. Whilst it could be argued that there is potentially a conflict of role here with the social worker, by concentrating on the health needs of the community the health visitor could potentially shed her "child health expert" label and become more involved with public

health issues within which the clients could have a more participative role. The NHS and Community Care Bill (DOH, 1990) may well determine which direction health visitors take.

Differences in expectations of the home visit between HVP and non-HVP clients

As shown in Table 13, there were some small differences in the expectations of clients from the process and non-process groups. For example, 5 (12.2%) of clients in the HVP group expected nothing from the visit whilst 7 (20.6%) of the non-HVP group expected nothing. Although small, this difference cannot be immediately explained by the usual visiting pattern as clients from both areas were usually visited by appointment in similar proportions (48% HVP, 52% non-HVP) and the clients who were *not* normally visited by appointment were no more likely, in either group, to expect nothing from the visit.

A larger difference between the two sets of visits can be observed with respect to the expectation of reassurance (39% HVP, 29.4% non-HVP) and the expectation of developmental assessment being carried out during the visit (7.3% HVP, 20.6% non-HVP). Again, these differences are hard to explain in isolation but it is possible that the two groups of clients held different role expectations of the health visitor which would explain in part why their expectations from a visit from the health visitor differed. For example, it was apparent from the observed visits and from discussion that the non-HVP health visitors carried out developmental assessment in the home more routinely than the HVP health visitors, thus defining themselves to some extent as child health experts.

Clients' perceptions of health visitors role

Clients were asked by the researcher to describe how they perceived the role of the health visitor. It was found that although generally positive, this was described largely in non-specific terms by both groups. For example, some comments on the health visitors role from the non-HVP group were as follows:

> "To give advice, a calming influence, reassuring. You think you're the only one it ever happened to."
>
> "To sort out anything like this (infant feeding), to give reassurance that it's O.K. to do something, to check their weight."
>
> "To advise and help with the baby. It's nice to have somebody, especially with the first baby".
>
> "Someone to give advice to do with yourself, your family. It's very important to know there is someone who can give you professional advice and support or refer you to other professionals."
>
> "I haven't used them to the full advantage, I just ask them about feeds etc. Other people rely on them, I try to depend on myself".

It is interesting to note the frequency with which advice is cited as an aspect of the health visitors role alongside the reassurance aspect of her role. This conflicts with the more faciliatative role of the health visitor as recommended by the CETHV (1977). Sefi (1985) has discussed the prescriptive approach which health visitors in her study tended to take towards advice giving and this was supported by the findings from the current study and discussed in chapter eight. The perception of the health visitor's role as advisor on child health issues alongside the need for reassurance further supports the concept of the health visitor as child health expert. This would be supported by the tendency in the non-HVP group to carry out formal developmental tests in the home as this activity endorses the health visitors' role and function in child health.

Despite the small differences in expectations of the home visit, the clients in the HVP group had similar perceptions of the role of the health visitor to the non-HVP clients. For example:

> "They have a positive role in building the bridge between normal procedures in children and sickness in childhood."
>
> "They're there to help you and to give you advice sometimes without them you wouldn't know what to do, you panic."
>
> "For support, especially a new baby and the first five years. She is someone who is in the medical field who isn't a doctor, for example she came to see me when she heard the baby was having a scan."
>
> "Just as a support and guide, to check you are doing things the right way. You know there is always someone to call on, especially when the baby is small."
>
> "To give advice, somebody to discuss problems with."

There was a similar emphasis on the perceived role of the health visitor in child health advice alongside the supportive role. Whilst there is clearly some validity in parents expecting the health visitor to provide support and advice in child care it was interesting to note that very few clients saw the health visitor's role in relation to the health of the whole family or the wider community. One client expressed uncertainty:

> "I didn't know whether she had a role in bereavement. I lost a baby and I didn't know how to contact her."

Clearly, if health visitors shared the breadth of their role and expertise *with* clients then families would come to expect a broader based service in the promotion of health among all age groups. It appears at the moment that areas in which health visitors claim to have expertise such as bereavement, (While 1989) are being overlooked because parents only recognise the limited role of the health visitor in care of the under fives.

Summary

In summary, it appears that parents expectations of individual visits are defined by the general role expectation which they have of the health visitor. Thus, visits are largely expected to result in some aspect of advice or support on baby or child care and this appears to be the general view that clients hold of health visitors. This view belies the evidence that the profession as a whole would lay claim to a much broader role in community health promotion (CETHV 1977, Clark 1987, Orr and Luker 1985, Goodwin 1988). There appears to be little evidence from this study that clients perceive the health visitor as anything other than a child health expert.

Health Visitor's evaluation of the visits

Since the HVI was carried out very soon after the visit, the health visitors were asked to explain how they intended to evaluate a visit. Their responses are summarised in Table 14.

Table 14. Health Visitors' Evaluations of Observed Visits.

EVALUATION	Process n=41		Non-Process n=34		All visits n=75	
	n	%	n	%	n	%
Positive emotional	16	39.0	14	41.2	30	40.0
Negative emotional	4	9.8	3	8.8	7	9.3
Objectives fulfilled	20	48.8	11	32.4	31	41.3
Objectives unfulfilled	0	0.0	5	14.7	5	6.7
Client change observed	2	4.9	2	5.9	4	5.3
Client need observed	4	9.8	2	5.9	6	8.0
Further follow-up necessary	6	14.6	7	20.6	13	17.3
Difficult to evaluate	1	2.4	2	5.9	3	4.0
Other	3	7.3	4	11.8	7	9.3

More than one response was possible.

As can be seen, the health visitors selected a variety of approaches to evaluation ranging from a purely subjective response to the visit to looking at the achievement of objectives.

Subjective or emotional responses to visits were described either positively or negatively, for example:

> "I was satisfied with the visit - it was the first time I'd had a pleasant or jolly visit here."

would be categorised as a positive emotional evaluation as it describes the health visitors personal response to it, similarly:

> "I was pleased because father was there. It gave an extra dimension to it."

The more negative emotional evaluations were again related to the health visitor's personal response - that some felt disappointed or dissatisfied with the visit:

> "I wasn't very happy with the way it went. I felt dissatisfied when we came out"
>
> " I was disappointed that she didn't want to come to the group"

This type of evaluation is useful for exploring the health visitor's feelings about a visit and gives the health visitor the opportunity to reflect on her interaction. However, it has limited value as a method for measuring the effectiveness of a visit. It could be argued that it doesn't really matter how satisfied or disappointed the health visitor was if mutual goals and objectives have not been addressed. Nevertheless, 40% of all visits were evaluated subjectively to some extent and the response was similar for both groups (HVP 39%, non-HVP 41%). Additionally, it could be argued that the clients' subjective views of a visit are as significant in evaluative terms as the health visitors'. None of the health visitors discussed the possibility of asking the client how she felt about the visit as a method of evaluation.

However, almost half of all the visits (48%) were evaluated in terms of objectives being fulfilled or unfulfilled.:

> "I felt that the objectives were achieved, I was able to check on the baby's progress and discussed weaning."
>
> "I have assessed development - it is appropriate for age, the baby is gaining weight and not vomiting. Mother is attending the post-natal group and is therefore socialising and enjoying motherhood."

This type of evaluation gives a more accurate picture of the extent to which the health visitor considers the visit to have been effective. However, it will be recalled that frequently the health visitor's objectives and perceived needs were not in agreement with the client's objectives and perceived needs. Therefore, evaluation which uses only the health visitors objectives as a measuring tool cannot give a completely accurate assessment of effectiveness. Only by sharing this process of evaluation with parents could this be achieved and this in turn would depend on gaols and objectives being mutually defined and clearly, in many cases, they were not. Some health visitors appeared to acknowledge this in an oblique way when talking about evaluation:

> "I don't think we had a clear enough plan about the sleeping problem, we didn't come to a firm decision."

This seems to indicate that this health visitor recognises the importance of reaching some goal or plan in negotiation with the client and that evaluation is likely to be inadequate without this.

Some health visitors (5.3%) evaluated the visit in terms of the client having changed in some way:

> "I felt pleased because there had been a change - Mum was more in control and less anxious."

This type of evaluation suggests that a previous goal had been set in relation to client change. However, it does not give any indication that the goal or the outcome were satisfactory or appropriate to the client neither does it illuminate the factors contributing to the change. In other words, the health visitors did not appear to use a process approach to evaluation of their practice as proposed by Donabedian (1968).

Some health visitors appeared to have little understanding of evaluation and stated that they found the visit "difficult to evaluate" (14%). This was largely put down to contextual difficulties of the visit such as presence of grandparents or communication difficulties with the client, although there was little evidence of reflection on what caused the communication problems. A further 17.3% felt that evaluation would not be valid without further follow up to ascertain if goals had in fact been met.

Summary

In summary, a variety of approaches were taken to evaluation, the most likely of which were either to express the health visitor's subjective response to a visit or to evaluate in terms of the achievement of health visitors objectives. There was little consideration of including the client in evaluation. Even where a change had been observed the process leading to this outcome did not appear to be considered as an appropriate evaluation exercise. Thus, effectiveness of a health visiting intevention is only measurable, from the point of view of the health visitors in this study, by the achievement of the health visitor's objectives. Exploration of the transcript data in chapter seven throws some light on the process of reaching objectives and setting goals.

Conclusion

In conclusion, this chapter has presented findings from the interviews conducted with both health visitors and clients. Whilst a number of facets of the home visits have been explored, several main themes have emerged from these findings. The first major observation is that whichever stage of the visit is addressed, the health visitors and clients do not hold congruent perceptions. This has been demonstrated in terms of perceptions of the purpose of a visit, perceptions of perceived need, perceptions of a perceived plan and perceptions of perceived follow-up. These incongruent views have been supported by further evidence from the clients about their perceptions of the health visitors role and from the health visitors' views on evaluation. These findings suggest that there is little negotiation between health visitor and client about these

issues and that therefore client participation is minimal. It is suggested that this finding may be partly explained by the emphasis on the health visitors role as a child health expert. Such perceived expertise precludes the client from interacting on an equal basis and thus expert advice is more the expected norm than a participative approach to needs appraisal or mutual goal setting.

A second observation is that very few differences have been found between the HVP and non-HVP groups in terms of client participation measured by congruence of perceptions. This suggests that the HVP as it was implemented in this study did not contribute substantially to enhancing client participation. This could be partly explained by the health visitors comments on the way in which the HVP was interpreted and implemented. It was perceived more as a management tool than a philosophy of care. This would suggest, alongside the emphasis on the child health expert, that the HVP does not provide an adequate framework for practising health visiting in a way which embraces client participation. It is possible that, in order to meet the goals of the HVA (1988) to increase client participation, the concepts basic to health visiting will have to be defined and a framework for practice which is grounded in these concepts devised. It appears that HVP on its own is not enough. This is discussed further in chapter eight.

Chapter seven addresses the processes involved in the actual interactions which took place during the home visits discussed above. This is followed by further discussion in chapter eight of the apparent absence of client participation and offers some explanation for this in the light of both sets of data and existing research.

Findings based on the Analysis of the Health Visitor -Client Interaction Data

Introduction

Qualitative data of health visitors talking to clients were collected from 62 visits. As discussed, in chapter five these data were collected through a process of non-participant observation and audio-recording of actual interactions. These interactions lasted from 15 to 55 minutes. The aim of gathering these data was to explore and describe the interactions in terms of both client participation and the influence of the HVP on actual practice. The successfully recorded tapes were transcribed verbatim and analysed using a modified approach to conversation analysis as discussed in chapter five. The observation data in the form of notes was used to add contextual detail to the interaction data. The categories which are discussed are those which emerged from the data itself and are identified as:

Agenda setting

Gathering and providing information

Giving and receiving advice

Closures

These categories represented the overwhelming majority of health visiting and client activity. Within each category several sub-categories were identified and these will be discussed in depth throughout the chapter. Within these categories it will be seen that the most remarkable feature of the analysis which follows is the overall lack of evidence of client participation in terms of clients being involved in setting their own agenda, contributing their perspective or experience of a topic, setting their own objectives or goals or being actively involved in decision making. As there is no notable difference between the interactions from the HVP and non-HVP areas they are largely treated as one data set throughout the chapter with examples from both areas being presented as appropriate.

Agenda setting

The first major theme to emerge from these data was that of agenda setting. This was identified by sequences which occured early on in the interaction and which gave some indication of the overall purpose of the visit. As discussed below, it emerged that a variety of approaches to setting the agenda were used and that it was overwhelmingly the health visitor who initiated agenda setting sequences. In 66 per cent (38) of the visits recorded, objectives were stated by the health visitors although it became clear that there were a variety of approaches employed by health visitors for this purpose. However, this meant that in one third of all the visits recorded there was no identifiable method of informing the client what the purpose of the visit was thereby leaving the agenda unclear. Where objectives were apparently referred to they were recognisable by their relatively early introduction into the interaction, thus providing the agenda for the remainder of the visit. Overwhelmingly, health visitors who gave objectives did not offer opportunities for negotiation or flexibility in the agenda and therefore in the majority of visits it became obvious that the agenda was set by the health visitor and that neither the health visitor nor the client apparently expected to negotiate either the contents or the order of discussion of the items. In an interaction where client participation is elicited, one would reasonably expect that the agenda for the visit would be a negotiated process, these data revealed that this was not the case in this study. These points will be illustrated more clearly in the following presentation of sub-categories of agenda setting.

Seven main approaches were used to establish the agenda. Six of these were health visitor initiated sequences and one approach was client initiated. These were categorised as: the broad question, the specific question, the evaluative question, statement of health visitor function, the goal related statement, use of child and client initiated sequences. An interesting and important observation was that there was no observable difference in the way agenda setting was approached between the HVP and non-HVP areas. Each sub-category will now be explored in turn:

a) The broad question

One way in which health visitors appeared to set the agenda for the visit was to ask a very broad question which was non-specific and not goal related and yet occurs sufficiently near to the opening of the interaction to indicate to the client that part of the agenda was to collect information. This was usually, although not exclusively, related to child health. There were thirteen examples of this approach, of which six were from the HVP area and seven from the non-HVP area, indicating that the approach was used by both groups to a similar extent.

For example: HV2E (HVP)

Line 3 Health visitor: ... so how are things?

Line 4 Client: Oh, not so bad, they're doing very well.

She's doing very well. Sleeping and eating. Yes.

In this example, the health visitor enquired about "things". There is no indication as to what she means. She could be enquiring about the client's marital relationship or the weather but in accordance with the principles of conversation analysis, the interaction appears to be organised so that the client knows how to respond and straight away relates the welfare of her children. The "things" on the health visitors agenda appear to be correctly interpreted by the client and issues of child health as the next sequence from the same interaction illustrates:

Line 7 Health visitor: She's sleeping through the night now?

Line8 Client: Oh yes. She goes down at nine and I don't hear her until about seven.

Line10 Health visitor: Oh - uh

Line 11 Client: In the morning.

Line 12 Health visitor: And we've started on tastes and things like that?

This sequence serves to illustrate how opening with a broad question gives the client an indication of the health visitor's visit agenda i.e. to find out more about the child's health. Without being specific, the health visitor was perhaps drawing on the clients

expectations of the health visitor's role. As discussed previously in chapter six, clients tended to perceive the health visitor as the child health expert. A further example of this broad question approach to agenda setting is illustrated by HV3B (HVP).

Line 3 Health Visitor: ... How are things anyway?

Line 4 Client: Alright. Apart from his cold, its been terrible.

Again in this paired sequence the health visitor appears to be broadly referring to her agenda of gathering information about the child's health and the client again apparently correctly interprets this. Interestingly, the mother's first response to the state of "things' is "Alright" which she then seems to correct by introducing the element of ill health in the child. Of the thirteen visits where this broad question approach was taken to objective setting, five clients responded with "fine" or "alright" and then went on to qualify their response usually by supplying the health visitor with some information related to the child's development e.g. HV7C (HVP):

Line 1 HV: So how has Louis been getting on?

Line 2 C: Fine. He's got one tooth just down.

The mothers appear to be interpreting the health visitors agenda correctly by focussing on child health issues. In some cases the broad question appears later in the interaction. In these cases it appears that the health visitor is implying "Now lets get down to the business I"m here for", as though the earlier talk was not significant, at least to the health visitors agenda. For example, HVX2E (non-HVP) asks the question at line 23:

Line 23 HV: So how are things going? Alright?

Line 24 C: Oh, alright.

Line 25 HV: Yes?

Line 26 C: Yes. She's O.K. I'm a bit worried about the snuffling because it hasn't stopped.

Again, the interaction has been steered into the direction of the baby's health, not by direct questions by the health visitor but by an apparent implicit understanding

between the health visitor and client that "things" refers to child health, that being the purpose of the health visitor's visit. In one case the health visitor even articulates that they are discussing a topic which was not on her agenda, albeit a very pertinent area of health education HVX7E (non-HVP):

> Line 6 HV: "I didn't mean this to be a lecture on smoking but now I've started I'll finish".

> Line 61 HV: Are you still worried about the baby?

From Line 6 - 60 smoking is the focus of discussion, but at line 61 the health visitor changes the topic to get back to her agenda. In this case the health visitor is more direct in her questioning at Line 61 but the case illustrates the way in which the discussion is brought the focus back to a child health agenda.

The Specific question

A second approach used to set the agenda was to ask a question related to a specific topic or event. Again, these were largely orientated around child health issues. The questions implied that the health visitors objective was to gather information about the specific topic in question. Usually they can be identified as agenda setting because they appear early on in the interaction, where they appear later (as with broad questions) the health visitor seems to be bringing the discussion back to what she perceives to be the main issue.

Four of the health visitors used this technique. There was no evidence that one group of health visitors used this strategy with any more frequency than the other since there were two examples from each area HV5A (HVP):

Line 1 HV: How's the group been going anyway? Have you been enjoying the group?

Line 3 C: Yeah, I think that's ever so good.

The group referred to in this case was a mother and baby group. Another example was HV1A (HVP):

Line 17 HV: Has he been alright after his injection?

Line 18 C: Yes, he was fine.

Line 19 HV: Good. That's fine. Cause that was his second one wasn't it?

As with the broad questioning, there appears to be a degree of acquiescence on the part of the client - the group was "ever so good" the baby was "fine" after his injection. In both techniques her agenda setting (broad and specific questioning) there appears to be an assumption by both parties that the health visitor is in control, that child health (as opposed to family health) is the main issue and other issues are rarely raised by the client. This is further illustrated by a further example from the non-process area HVX6C:

Line 1 HV: Right, so she's not been very well?

Line 2 C: No, I phoned the doctor this morning and they said like to get the result back could be as late as Monday.

Whilst in this example, the health visitor is making her objective known by the use of the specific question, the objective appears to match the mother's concern as her response to the question is intended to give the health visitor detailed information about the child's health, which differs from responses such as "Fine" and "Alright". It is apparent from the sequence that the health visitors objective was to gather information from the client about, in this case, an episode of ill health in the child and that by homing in on an area of natural concern to the mother, the health visitor obtained the information she required.

c) The Evaluative question

This type of question implies that the health visitor's agenda is to gather information in relation to a previous visit or plan. Thus, there is an element of evaluation of a previous contact. Such a strategy does make the health visitor's purpose very clear to the client but at the same time limits opportunities for setting a new agenda based on interim events or experiences. For example, HV3C (HVP):

Line 1HV: Last time I was here we actually talked about ..

Line 2 C: That's right starting him off (introducing), just with a couple of, Couple of spoons.

Line 7 HV: So he's taken to it alright?

The next 50 lines are spent discussing the baby's diet which was not apparently a problem for the client at this time.

The next example is an unusual instance of the health visitor setting an agenda which was not exclusively orientated around the baby's health, HV20 (HVP):

Line 3 HV: I did write to H & E, the housing thing. Has anyone been to see you?

Line 4 C: No.

Line 5 HV: Well, you should get a letter about it eventually because I did write a very full report to the housing authorities.

This was an interesting case where the primary objective of the visit appeared to be an evaluation of the housing problem. When the health visitor found that nothing much had happened in a practical sense since the previous visit she actually steers the discussion onto child health issues again, HV2D:

Line 11 HV: Right now, young man .

Line 12 C: Nine pounds yesterday!

It appears in this case that whilst the evaluation of the housing situation was an objective for the health visitor, the real business was assessment of child health as suggested by the expression "Right now".

This was a rarely used strategy employed by only three health visitors who, interestingly, were all from the HVP area. This might suggest that the emphasis given to evaluation in the HVP is reflected in the style used to communicate objectives of a visit to the client.

d) Statement of Health Visitor Function

Some further strategies for setting the agenda were to make a statement rather than asking a question. One technique was to make some statement about the function of the health visitor - either with direct reference to a specific task or in more general terms. Interestingly, there was little reference to the role of the health visitor which some mothers may not have been clear about. The statements could be classified as agenda setting as they occurred early on in the interaction and implied a purpose for visiting i.e. "I'm here because ....".

The function statements were not evaluative in that they did not refer to previous plans or goals set. Some statements were so vague as to what the health visitors intentions were that they appeared to assume that the client had some knowledge or understanding of the health visitor's agenda or alternatively that the clients were being offered an opening to set an agenda, e.g., HV1D (HVP):

Line 3 HV: I'm the health visitor. May I come in?

This statement was made to the father in this case and there is no indication that he is aware of why the health visitor has called except that he evidently allowed her into the house. This in itself suggests that the health visitor assumed her function was obvious from the simple statement of introduction.

A further example of this statement of function is illustrated by HVX4A (non-HVP):

Line 3 HV: I've brought the scales with me.

Line 4 C: Oh, good. Right.

Line 5 HV: Is our baby anywhere?

In this sequence it is apparently obvious that the health visitor has brought her scales to weigh the baby (as opposed to weighing mother or the toddler, for example). The statement suggests that this is an aspect of the health visitor's function and this is why she has called. There is no debate about the need for weighing - this is implicit in the statement. The client , as marked by the exclamatory term "Oh" apparently receives this statement as news but accepts the agenda as inidicated by "good" and "right".
Whilst these two examples of function statements suggest that the client was expected to acquiesce with the health visitor's agenda, a third example whilst stating a function does allow for some flexibitlity, HV9C (HVP):

Line 6 HV: O.K. Now what I'll do is....if its alright with you, there's all the paperwork etc. I'm afraid to go through. So if I do that first and talk to you and then I'll look at baby last. Is that alright?

Line 12 C: Yeah. That's fine.

The client does not voice any objections to this clearly structured agenda illustrating again the apparent passive acceptance by clients of the health visitors' agenda. It would be interesting, having offered the invitation ("Is that alright?") to see how the health visitor would have responded if the client had had an alternative agenda in mind. This approach to communicating the agenda by making a statement about the health visitors function was used equally by HVP and non-HVP health visitors.

e) <u>The goal-related statement</u>

A further strategy employed by health visitors for informing clients of their agenda was to make a statement which related to specific goals rather than just to function. These statements therefore, like the evaluative question, related to some previously defined plan. This type of statement apparently leaves the client in little doubt as to why the health visitor has called but by the same token leaves little room for negotiation of the agenda. The strategy was mainly used by one HV (HVX1) whose interactions were

unusual in the way that the health visitor exhibited a pattern of using this approach to setting the agenda. To illustrate this case the following extracts of agenda statements are offered, HVX1A (non-HVP):

> Line 1 HV: I called round; D., this morning to find out how you got on last week and what changes you'd noticed.
>
> Line 3 C: Well I don't want him to go there.
>
> Line 4 HV: You don't.
>
> Line 5 C: Um, its a lovely place, they've got fantastic toys (Mm) .. but its obviously only a place for problem children isn't it?

In this example the health visitor has made it very clear why she has visited, relating her objectives back to a previous contact. Whilst she does not overtly offer a negotiated agenda she gives the client the impression that the client is in control by her apparent acceptance of the client's decision (Line 4: You don't). However, later on in the interaction, the client having expressed considerable anxiety about the family centre, the health visitor does assume some control over the interaction:

> Line 17: Can you remember the reason for going in the first place, why I felt it would be helpful?

Whilst this specific question seems to re-establish the objectives it also suggests that control is assumed by the health visitor - note that she (the health visitor) had felt the family centre would be helpful, not the health visitor and client in participation.

Another example from the same health visitor illustrates this technique further, HVX1C:

> Line 4 HV: Well, J, I've called round this morning to find out what happened ...
>
> Line 5 C: I didn't take him.
>
> Line 6 HV: You didn't.
>
> Line 7 C: No. Cause I know, it was his teeth, definitely was.

Line 8 HV: You didn't take him to the doctors?

In this sequence the health visitor has set the agenda by stating that she has called to find about the results of some previous advice. She discovers that the client evidently did not follow through the plan made on the last contact and whilst giving the impression of accepting the client's decision (line 6: You didn't) she again attempts to re-assume control later in the interaction when the client has given her reasons for not following the plan through.

Line 26 HV: But you were really wondering whether his constipation was causing him to wake up at night in pain. (Mm) And you were really wondering whether it was causing him sleepless nights weren't you?

Again, the agenda is re-established by the health visitor putting it back within her control. It is notable that the opportunity for attending to the client's agenda (line 7, "it was his teeth") has been overlooked.

All four of this health visitor's recorded visits follow a similar pattern, for example

HVX1B:

Line 1 HV: I called to see you Mrs M. just to see how you're getting on with G. really

Line 2 C: Yes

Line 3 HV:and how are you feeling because you weren't very well.

Again this health visitor has made an explicit statement of her agenda which the client passively accepts. This health visitor was unusual in having a recognisable pattern in the way she approached her interactions. Her style does present a dilemma for although she did make it clear to clients what she intended to cover during the visit, she did not provide openings for negotiating the agenda. The majority of the other health visitors in the study used a mixture of strategies for setting their agendas.

f) Use of the child

One further strategy employed by three of the health visitors was to indicate the purpose of the visit by talking to the baby rather than the parent. This could be perceived as a display of friendship to the mother by interacting with her baby or as a subtle way of getting a message across, for example, HVX2D (non HVP):

> Line 5 HV: Shall we see what you can do in my box of tricks today, shall we see what you can do?

Here the health visitor is indicating that she will be carrying out an assessment of the baby's development, specifically in terms of what the baby can "do". Another health visitor referred to what she was going to do to the baby by talking to one toddler, HVX4A:

> Line 14 HV: I've brought my scales with me today so we can see how heavy J. is.

By talking through the baby or other young family members the health visitors can inform the parents of an apparently simple or obvious agenda without the parent losing face if she isn't sure what is going to happen. It also ensures, though, that the health visitor maintains control over the agenda because she is not asking the parent whether she may carry out an assessment or weight the baby, she is telling the child. The child cannot enter into negotiation and it is unlikely that a parent would dispute the need for such activities because of the way in which the conversation is socially organised with the health visitor's objectives even when directly confronted with them; so it is unlikely that they would argue with an agenda which is set through the child.

g) Objective setting by the client

In one case there was an observable sequence in which the client assumed control and set the agenda for the visit. In this case (visit HVX6B non-HVP) the interaction opened with some general social chat to the baby and some comments about the baby's weight. At Line 9 the health visitor begins to set an agenda for assessing development of the baby by asking a specific question:

Line 9 HV: What's he started doing now, is he crawling yet?

Line 10 C: He tries, yeah, he tries, don't you, 'cept he goes backwards not forwards.

The talk continues about the child's crawling and speech until at Line 23 the client finds an opening for introducing her own agenda. The opening appears to be offered when the health visitor ends the previous sequence with a comment about the baby's activity:

Line 22 HV: Oh, his interest is going that way.

Line 23 C: Dr Allen said something about I should get in contact with you and then you'd come and tell me what to do about his food.

Line 26 HV: Right. Well, you tell me what's happening first of all. What did you say to Dr Allen?

In Line 22 the health visitor has not asked a question or made a specific observation which requires comment by the client. The pattern of the sequence was thus broken, providing the mother with the opportunity to assume control by setting the agenda which was important for her - the baby's dietary needs.

Assessment of the baby's behaviour and requirements continues for the next 100 lines and the topic is returned to twice during the whole interaction indicating that this is an important subject for discussion for the mother. It is interesting to note that whilst the client has assumed some control over the interaction by setting the agenda she is also handing back control to the health visitor by suggesting that the health visitor will tell her what to do about the infant's diet. As previous sequences have indicated that mothers acquiesce with the health visitor's agenda to a large extent, the verbal behaviour in this case could suggest that clients *expect* health visitors to be in control as they perceive them to be the experts in child health.

Cases where no agenda was set

Whilst the findings from the analysis of the interview data (chapter six) indicated that all the health visitors had at least one objective for the visit, there were 20 cases where

the sequences described so far were not obvious from the transcript data. This suggested that there were a sunstantial number of visits where the client was even more uninformed about the health visitor's agenda and even less able to negotiate her own. Ways in which these cases differed from those previously discussed will be suggested.

Social talk

Some of the health visitors who did not employ any of the above strategies for agenda setting used social talk as the opening which tended to drift into information gathering without supplying any information about the visit agenda. Social talk was identified as talk which was not orientated around family health but referred to the weather or aspects of the home etc. This technique could be perceived by the client and health visitor as a "friendly" was of opening the interaction but it neither informs the client of the health visitor's agenda nor invites the mother to negotiate her own.

For example, HV4D (HVP):

> Line 1 HV: I've been doing some painting, I've been painting my hall, I've been explaining this to everyone ...
>
> Line 3 HV: I notice that she's still got a sticky eye.
>
> Line 4 C: She's got it all the time.

This sequence appears to differ from those previously discussed in that the health visitor does not use any of the identified strategies for informing the mother of her agenda. Instead, she starts the interaction on a social tack and then moves into information gathering almost immediately i.e observation of the sticky eye. She does not say directly or suggest indirectly that she has come in order to observe the child's health, she is making an observation *as it arises*. This, arguably, leaves the agenda more open, addressing needs as they arise. However, it is also so loose as to potentially leave the client in a state of uncertainty about the health visitor's purpose. The client was unprepared and could not therefore plan ahead with questions which meant that the health visitor was able to maintain control of the interaction. In addition, this

health visitor had outlined very clear objectives to the researcher in her interview, indicating that she could have given the client this information more clearly. A similar argument could be applied to the second approach used by health visitors who did not use any of the identified agenda-setting techniques, that of moving straight into information giving without social talk or agenda setting.

Opening by information gathering

The nature and techniques used for information gathering will be discussed fully in the next section but, in general, information gathering could be identified by the question and answer sequence, often followed by a comment or advice giving by the health visitor. This pattern was identified in six of the interactions where other agenda setting techniques were not employed.

For example, HV3A (HVP):

Line 2 HV: So she's smiling at everybody?

Line 3 C: Yes, yes.

Line 4 HV: And she had her six week check the other day, that was alright wasn't it?

Line 6 C: Yes it was fine.

In this sequence the health visitor is opening with an assessment of the baby's development based on her observation at the time. There is no indication that she was visiting the family *in order* to carry out a developmental assessment. This approach therefore appears to differ from the specific question technique discussed earlier in that the question (or statement) is based on a current observation rather than on pre-planned agenda. The same observation can be made from HV4C (HVP):

Line 1 HV: She's sucking better.

Line 2 C: Yes, on this teat, depending how hungry she is.

Here, the assessment is more a statement of an observation than a question but the result is the same - the sequence leads into discussion of a topic which the health visitor has instigated, leaving no opening for the client to set the agenda for the visit.

Summary

A major finding from the interaction data was that there was little evidence of client participation. This has been illustrated with reference to the way in which the agenda for a visit is set. The health visitors in this study appeared to use a selection of techniques for setting their own agenda which were invariably centred around child health issues. The strategies employed precluded the client from negotiating an agenda for the visit and thus the health visitor maintained control over the interaction. In some cases there was no identifiable agenda set and health visitors either used social talk or direct observation to initiate the interaction. In a single case where the client was apparently able to set her own agenda, control was relinquished to some extent by the expectation that the health visitor would tell the mother what to do. In the majority of the interactions there appeared to be a high degree of acquiescence on the part of the mothers, indicating an implicit expectation that the health visitor is in control of the visit.

Gathering and Providing Information

For the purpose of the analysis of this aspect of the interaction, the collection and provision of information was identified as any sequence in which the health visitor attempted to find out about family needs, problems or resources or any sequence in which the client articulated her perception of the family or individual needs; either in response to the health visitor or initiated by herself. Eliciting and understanding the health needs of the family as perceived by the client is clearly essential to the negotiation of any health promotion action which the family decide to take.
To this extent, one could expect to find evidence of health visitors eliciting the health beliefs of the client and trying to understand and share the client's ideas about the

health of the family. However, in this study it was found that sharing of ideas was rare and that identified health needs were largely based on the health visitor's agenda. Thus health needs as the clients perceived them could not readily be addressed.

Within this section, examples of information gathering sequences will be used to demonstrate the lack of client participation in the identification of needs or problems. In general, the health visitors having set the agenda for the visit, tended to adhere to their visit objectives and to prioritise the needs as they perceived them. Thus, it was unusual for clients to be asked directly what their perception of their needs was and clients rarely took control of the interaction by changing topics or asking the health visitor a question. Where clients were asked if there was anything they wanted to talk about this almost exclusively occurred where the interaction was obviously closing. Clients might have felt inhibited about opening up the interaction again. This issue is discussed in detail later in the chapter under the heading "Closures".

Several approaches were taken by health visitors to the process of information gathering. They included question and answer sequences, where the health visitor asked the questions, question and answer sequences with commentary and observation by the health visitor followed by commentary from the client. Rarely, the sequence would be opened by the client asking a question.

a) The Question and Answer Sequence

One approach to information gathering was the question and answer sequence. In this technique the health visitor asked the client a direct question about a specific topic to which the client responded. The health visitor then had a choice of two pathways - either to go on to the next question or to respond to the client's answer with a comment, some information or some advice. The nature of the paired sequence of question and answer made it almost impossible for the clients to respond in any other way than to answer the question. It was unusual, for example, for the client to respond with

another question or to change the topic. This type of sequence was more likely to occur towards the beginning of an encounter when the health visitor appeared to be gathering a data base of information from which selected needs as perceived by the health visitor could be dealt with later in the interaction.

There are numerous examples of the question and answer sequence since all the interactions include at least one example of it. The following example from the (HV2E HVP) area is typical of sequences where the health visitor elected to move on to the next question:

Line 7 HV: Yes. She's sleeping through the night now?

Line 8 C: Oh yes. She goes down at about nine and I don't hear her until about seven ...

Line 10 HV: Uh - uh

Line 11 C: ... in the morning.

Line 12 HV: And we've started on tastes and things like that?

Line 13 C: Oh yes. She's on, um, solids now. She's um, I started her this morning actually with a bit of breakfast (Uh -uh) so she's having three (Yes) three a day now.

Line 19 HV: And you'll soon be cutting out a feed now, won't you?

Line 20 C: Oh yes.

In this sequence the health visitor chose to continue with her questions attempting to gather data rather than respond to the client. However, it is the way in which the questions are posed which is interesting. Whilst collecting her information the health visitor appears to be seeking affirmative responses, thus exposing her own expectations of the child and closing any opportunities the client may need to give negative responses. Indeed, the client may feel it is not acceptable to respond negatively. This is particularly obvious at Line 19 where by adding "won't you" to the end of the question the health visitor in fact leads the client into a positive response. There is no further

exploration of this issue or "cutting out a feed" except that at Line 21 the health visitor tells the client it will be "the lunch time one". The style comes across as being almost interrogative but is not unusual in the data as a further example demonstrates:

HV1A (HVP):

Line 31 HV: So what's he doing with his eating? How's he doing with his food?

Line 32 C: Oh alright really, on the whole aren't you? Well, he's on three meals a day still and er..

Line 34 HV: Yes, and does he have a pudding as well as a savoury at this time?

Line 35 C: Yes, and a drink of fruit juice.

Line 30 HV: And juice. So what about breast feeds now, what are you doing?

In this sequence the style remained interrogative by the apparent bombardment of multiple questions but the questions themselves are more open than in the first example.

The question arises, what are the health visitors doing with all the information they are accumulating in this way? Are they using it to formulate health objectives with the client or are they simply storing the information for its own sake, possibly as a way of maintaining some control over the family in terms of the more knowledge they have about the family the more they can control the family health patterns. Possibly they were seeking to confirm a particular behaviour pattern within the family.

Further analysis of sequences from the non-HVP area illustrates how this question and answer sequence serves to provide the health visitor with a "data base" of information from which she can select matters which she perceives to have particular relevance or concern to the client.

For example, HVX6B is assessing the nutritional intake of the infant:

Line 60 HV: Right, and what are you giving? All tinned food, packet food?

Line 61 C: Packet it is. Robinsons.

Line 62 HV: Robinsons

Line 63 C: Packet stuff it is (right). Three spoonfuls of dry powder to three of water.

Line 64 HV: And thats all the feeds are that, are they?

Line 65 C: Yes.

Line 66 HV: Right, how's he taken to that?

Line 67 C: He seems alright apart from he's a bit loose at the other end. Um, whether thats because of the food or ... he's just not used to it yet.

Line 69 HV: Tell me, when did you change over? Last week?

Line 70 C: Yeah, er, it must have been Thursday morning, Wednesday last thing, one day last before I took him up the clinic anyway.

Line 72 HV: Right. And has he been sick on his food?

Line 73 C: Um, not as much but he still being sick.

Here, the health visitor appears to be asking a series of questions, building up a bank of information about the baby's diet. The nature of the questionning at lines 60, 64, 66, 69 and 72 would suggest that the health visitor is organising the information in order to give the client some information or advice but instead she moves on to analysing the consistency of the food:

HV Line 89: ... just tell me, is it Boots, is is very smooth stuff or has it got little lumps in it?

It is not until line 123 that the health visitor returns to the baby's loose stools, an issue which was inferred by the client at line 68 as being a problem:

Line 123 HV: Right, now, you're saying that his stools are loose now.

Line 124 C: Mm. Very loose it is.

The significance of this sequence is that the conversation assumes a question and answer pattern, largely controlled by the health visitor's desire for information and which achieves very little. Indeed, the same point may have been reached similarly by asking the client if she was having any problems with the child's diet. The client cannot be described as participating in this sequence because she has no control over the content or the topic of the questions. The client cannot introduce her own topic with any immediate impact because sequential implicativeness would suggest that questions are responded to and the health visitor does not yield control of the topic to the client. When the client did attempt to introduce her own perceived needs as at line 67, these were overlooked. The value of asking one meaningful question which relates to the client's perceived needs can be seen from a further example, HVX6A:

> Line 29 HV: What happened about the breast feeding? You rang me up didn't you?
>
> Line 30 C: I was going to talk to you about that actually. I'm going to put her on the bottle, I think. I've survived till now but I"m just not doing enough. I eat all the time, but she's hungry all the time. I was doing a top-up feed in the evenings but I'm having to do one at lunch time as well now, 'cos as the day goes on she's getting hungrier and hungrier I've noticed.
>
> Line 35 HV: Right. Are you not comfortable breast feeding?

Whilst this sequence ends in another question, the primary question is more open than in previous examples and has allowed the client to introduce the issues that are troubling her. In this case, the fact that the baby seems hungry despite top-up feeds and the mother's diet being adequate. Even so, by asking another question the health visitor loses the opportunity to allow the client to express and explore ways of meeting her needs since the health visitor has effectively blocked the interaction with her next turn and does not acknowledge until Line 100 that the client actually wants to stop breast feeding.

> Line 100 HV: So you'd rather forget it completely?
>
> Line 101 C: Yeah. I'd rather.

In summary, the question answer sequence as a technique for collecting information may be used simply as a way of building up a data base of information or may be used more constructively to collect information which is relevant to the clients' needs. This would appear to depend on the way in which the sequence is initiated and the extent to which health visitors use their next turn as an opportunity for further questionning.

b) Question, answer and comment sequence

The question, answer and comment sequence was identified as information gathering as the health visitor initiated the sequence by asking a question, indicating a request for information, the client responded and, in this type of sequence, the health visitor completed the sequence by making a comment which could take a variety of forms. The comment could either by i) accepting or acknowledging the client's response, ii) clarifying the response, iii) casting judgement on the response or iv) offering advice. This type of sequence tended to occur later in the interaction suggesting that the health visitor was "homing in" on a need previously defined by the question/response sequence. Examples of each of these types of sequences will be presented.

i) Accepting/acknowledging client response

The first type of commentary appears to accept or acknowledge the client's response to the question, which either invited the client to confirm her previous response or to elaborate further. For example, in visit HVX6C (non-HVP), the health visitor is explaining the dietary needs of the baby and the change from milk to mixed feeding:

Line 162 HV: ... Um, right foodwise do you know what sort of food to give?

Line 163 C: Not really.

Line 164HV: You don't know anything much about it.

Line 165 C: No (At all).

Having asked the client about her knowledge of weaning foods the health visitor establishes that there may be some need for advice or information which she goes on to give (not shown). At Line 165 the health visitor acknowledges the word "much" ,

implying that the mother may know something but probably very little. In this case, the client then confirms the health visitor's acknowledgement (Line 166, No) and this enables the health visitor to move comfortably into giving advice. Whilst the health visitor has established that the mother has limited knowledge in this area she did not then establish what, in fact, the mother *did* know, thereby running the risk that by going on to give advice she may well be covering ground which is, in fact, familiar to the client. The health visitor is also failing to elicit what the client's health beliefs may be in relation to weaning which may also be indicative of whether the advice she goes on to give will be accepted or rejected.

ii) Clarifying the client's response

The second type of comment which health visitors use to complete a question/answer/comment sequence is a clarifying comment which may involve summarising, reflecting or paraphrasing the clients previous turn. This type of comment enables the client to expland on her response thus providing the health visitor with a more extensive range of information on which to base her advice.

For example in visit HV8D from the HVP area the following sequence occurred:

Line 257 HV: How do you feel about trying some sort of night time management? (Laughter)

Line 258 C: I've warned my neighbour.

Line 259 HV: You have warned them, right.

In this sequence the health visitor's question suggests by the presence of laughter an element of light heartedness. It could be for this reason that the client does not directly respond to the question i.e. she does not say how she feels about night time management of the baby. Instead, she says what steps she has already taken. The health visitor, by clarifying this position at Line 259 then leaves the next turn open to the client who does in fact expand on her response:

Line 260 C: I warned them because they're a young couple and I said, so you hear at night? because I was a bit worried ...

This next turn for the client has exposed her concern in relation to night management - that the baby might wake the neighbours, a legitimate concern given the close proximity of adjacent flats. This concern was then explored by the health visitor and client and found, in fact, not to be a problem. This type of sequence could therefore be identified as being participatory in that by clarifying the client's response to the health visitor's question the client is then encouraged to expand before an advice sequence is moved into.

iii) Judging the client's response

A third type of comment from the health visitor in the question/answer/comment sequence has a judgemental tone. The judgement can be either approving or disapproving but either approach indicates to the client what the health visitor's position is on a particular issue. Inferring judgement on the client's response to a question serves to confirm the authoritative position of the health visitor and, as will be illustrated later, can have the effect of making the client change her stance on a problem or issue.

This judgemental tone is characterised during visit HV1B (HVP). For example, a judgement of approval is evident in the following sequence:

Line 760 HV: She's still being good at night?

Line 761 C: She's very good, yes ... I put her to bed and went about 8.30ish and my Mum said she slept right through the night ...

Line 763 HV: Oh, that's wonderful!

In this sequence, the question itself is value-laden. What is meant by a "good" baby? . The client correctly infers that the health visitor is referring to the baby's sleeping pattern and in particular to the fact that she "sleeps through". The health visitor demonstrates her strong approval of this behaviour at Line 763. Such a judgement, whilst serving to reassure the mother, is only reasonable in the sense that the baby behaves in a way construed by the health visitor to be "good". The converse argument

would suggest that had the mother responded differently then the baby might be perceived to be "bad" and as such a product of the mothering she had received.

The disapproving judgement leaves no ambiguity about the health visitor's position in relation to a particular issue. For example, in the following sequence the infant's nutrition was being assessed by the health visitor, HV1B (HVP):

Line 170 HV: And er, she has a little egg?

Line 171 C: She has an egg every day, one every ...

Line 172 HV: I wouldn't give her one every day, I think that's too much, yes ..

In this sequence, the health visitor's first question is leading the client into an affirmative response. However, the health visitor is clearly unhappy about the situation and by showing her disapproval is undermining what the client has presumed to be the desired response and (by implication) mothering behaviour. The strength of this judgement, in fact, leads to the client changing her information to suit the health visitor's advice. At Line 180 she says:

Line 180 C: There are odd days, you know odd days when I do tend to miss it.

Despite having been quite clear at Line 171 that egg was given daily, the mother at Line 180 has altered her information to find a more favourable position with the health visitor. By casting judgement on a client's behaviour or decision the health visitor is not encouraging participation as her own beliefs and values are, in fact, undermining the mother's control and expertise.

The concept of the "good" baby was one which emerged strongly from the data and "good" was perceived to relate in particular to babies who slept through the night and ate their food. Mothers whose babies did not conform to this image were perceived by the health visitors (and to some extent by the mothers themselves) to have a problem. The data suggest that "good" babies are constructed by health visitors as a way of praising mothers whose babies behave in this way and as a way of delivering advice to mothers whose babies do not. The mother's *own* health was therefore perceived to be a product

of whether the baby was "good" or "bad" rather than an issue in its own right. For example, if a baby does not sleep through the night there may be a need for the mother to find ways of lessening her own fatigue. No such issues were addressed.

A further extract from the data strengthens this analysis, HVX6A (HVP):

Line 4 HV: Has she been sleeping through the night yet?

Line 5 C: Not through, in fact ...

Line 6 HV: Not yet.

Line 7 C: She's, touch wood, she's been rotten again. She's had two good nights (oh, good) from about ten and woke up at half five.

Line 9 HV: Oh, well, that's not bad is it?

Line 10 C: And I thought, oh good. But not last night she didn't. She slept all evening, when she doesn't normally sleep in the evening. ... she slept till half eleven.

.

.

Line 19 HV: That's good, isn't it?

In this sequence the health visitor commences her information gathering very early on in the encounter (line 4). She pre-empts the client's response at Line 6 with "not yet" suggesting that if the baby isn't sleeping through yet she ought to soon. The client then speaks of two "good" nights which the health visitor twice reinforces using the value laden language of "good" and "bad". There is consensus from the client at line 11 that this is the behaviour she desires and again at line 19 the health visitor reinforces the pattern of behaviour. The whole sequence, whilst not directly referring to the mother's own state of health, appears to be inferring that if the baby is "good' then the mother must be managing. This is confirmed at line 26:

C: .. well, if she sleeps the way she has been, I"m alright. I can get about seven hours. can manage with that.

To reiterate: the mother's own health does not appear from such data to be an issue in its own right worthy of consideration, but rather an implicitly accepted product of whether the baby is "good" or "bad".

iv) Giving advice in response to the clients response

One further way in which health visitors managed information gathering was to move immediately from questioning and hearing the client's response, into advice giving.

Analysis of how the advice itself is offered will be addressed in the next section, but here examples of the question/response/advice sequence will be offered with some comments as to why such an approach is non-participatory. The first example is from the non-process area, HVX7E:

Line 222 HV: Do you change him at the beginning, middle or end of a feed?

Line 223 C: What nappy wise? Yes, some times change him after, sometimes change him afterwards.

Line 225 HV: Probably best if you change him in the middle and then wake him up when he starts to get dopey, make that the time to change the nappy and liven him up again, because he's obviously sucking away and enjoying it and just going into a nice sleep. So as you say if he's not getting enough food into his tummy he's going to wake up dissatisfied. So lets try that. Do you bath him in the morning or at night?

In this sequence the health visitor has responded with a question to an earlier statement by the client that the baby drops off to sleep during a feed. Following the client's reply that she generally changes the nappy after a feed, the health visitor then goes straight on to advise on how to handle the problem. The sequence is perceived to be non-participatory in that the health visitor has not explained the possible significance of the timing of nappy changing nor has she allowed the client space to explore her own explanations of the baby's sleepiness. By completing the advice giving

with "lets try that" and moving onto the next topic, the health visitor is effectively closing this sequence of assessment and indicating that the need has been identified and dealt with. By giving advice rather than seeking to elicit the client's own beliefs and explanations of a problem or issue the health visitor is effectively maintaining control over the encounter.

A marked feature of the question/response/advice sequence was that the health visitor's advice turns tended to be relatively long. In some instances advice was administered for 20-30 lines of conversation. This compares with the previous modes of information on issues where one or two lines of talk were more likely. This suggests that advice giving has a controlling function - the "expert" giving information and advice to the "ill-informed".

In summary, health visitors used several approaches to information gathering through the use of questions. The first approach was interrogative in style and appeared to be an expedient method of data collection using the health visitors agenda although it is unclear how the data is processed by the health visitors. A second approach involved the health visitor providing some line of commentary following the client's response to an initial question and this commentary has been identified as confirming or accepting the client's response, clarifying the response, casting judgement on the response or giving advice. Only the clarifying category was seen to be participatory as it allowed the client to explore further their beliefs and values surrounding a particular topic.

Collecting information by making an observation

A final but important category identified from the data which health visitors utilise to collect information is that of observation. This technique was used less obviously than direct questioning. It involved making an observation of a current perceived psychological or physical state, usually, although not exclusively, of the child.

Observation was expressed in the form of a statement rather than a question and therefore took the form of an assumption. This allowed the client to expand on the observation, either by validating the health visitor's observation and providing the health visitor with further information or by repudiating the observation. The usual pattern in this type of sequence was that the health visitor would complete the sequence with further commentary, effectively either closing the sequence or moving onto a qeustioning sequence. As will be illustrated, the health visitors tended to use the concept of normative need as a basis for their observation, usually to the exclusion of felt or expressed need.

The first example of this approach is from the HVP area and demonstrates how a simple observation can give the client the opportunity to expand on the topic and provide the health visitor with information and introduce client perceived needs at the same time, HV4C (HVP).

Line 1 HV: She's sucking better.

Line 2 C: Yes, on this teat depending how hungry she is.

[Six lines on teats]

Line 8 C: But she has her moments and over the last two days she's thrown up every feed again.

Line 9 HV: I can't think that she throws up the whole feed every time because she wouldn't be ...

Line 11 C: [6 lines describing amounts of milk given and vomited]

Line 17 HV: Yes and she's gaining weight. And you don't do that on fresh air, do you?

In this extract the health visitor opens the sequence by commenting on the baby's sucking technique. This leads the client to both describe the different teats she has tried and also to reveal a perceived problem, that of a baby who apparently vomits her feeds.

In this case, despite having collected relatively more information than she would have done by the interrogative approach, the health visitor at line 9 chooses to reject the client's perception of the problem. This leads the client to give a full description of the amounts of milk given and vomited, to which the health visitor's response at line 17 is again to reject the mother's perception of her problem. The example illustrates how the gathering of information can be of little or no benefit to the client if her beliefs and worries in relation to the information are not explored by the health visitor. It also illustrates the inherent judgemental control that the health visitor can maintain over the encounter since having provided the opening for the client to provide information ("She's sucking better") the health visitor maintains the control over how the information is interpreted and utilised. The health visitor's judgement of the need revolves aound the baby. She apparently utilises the concept of normative need in order to make her observation. In this case she perceives the baby's weight to be normal and therefore rejects the mother's problem (lines 9 and 17) which is based on felt need - the mother is concerned about the baby's vomiting no matter how "well" the baby appears to be.

The concept of normative need was commonly used by the health visitors as a basis for their observation. Frequently, it was used as a way of conveying to the mother that the baby was in fact developing or behaving within normal boundaries. For example, HVX3E (non-HVP):

> Line 54 HV: She sits very nicely. Got a lovely straight back.
>
> Line 55 C: She does now but, um, she wasn't putting her legs out [no] to balance her ....
>
> Line 57 HV: Yes, fine.

Here, the health visitor observed the baby's sitting technique and conveyed to the mother her approval. The observation was clearly based on the health visitor's model of what a normal eight month old baby should be doing. There appears to be a slight element of doubt on the client's part ("She does now but ...") but this is rejected by the

health visitor at line 57 who has made her assessment of the baby's development by comparison with the norm.

In another example from a different visit involving the same health visitor, the health visitor again uses the observational technique to gain information but in contrast to the previous two examples the client concurs with the health visitor, HVX3C (non-HVP):

Line 191 HV: He looks as if he's growing nicely.

Line 192 C: Yes, yes he is. Very well. He has a good feed and then stops whereas she, used to have little bits ... of things just here and there. But now he feeds really well and he sleeps.

In this example the health visitor has used her knowledge of normal child development to assess the child's growth and to make a positive observation about it. The mother is thereby encouraged to provide the health visitor with further information related to the baby's growth - the facts that the baby eats and sleeps well.

Rarely, the health visitors used the observational technique to point out to the mother that (compared with the norm) all was <u>not</u> well with their child. For example, HV8D:

Line 131 HV: You see I was just watching her there when she was just sitting still looking. She's actually tilting her head back.

Line 134 C: Hmm.

Line 135 HV: As if she's got ....., as if she's um ..

Line 136 C: Yes.

Line 137 HV: But that, whether that's because she's looking up at me.

Line 139 C: She does tend to ...

Line 140 HV: ... and I've not noticed her do that before.

Line 141 C: No, she tends to put her head in funny positions to talk to you.

In this extract the health visitor is concerned that the child may have a squint and she is trying to put this across to the mother through observation of the way the child tilts

her head to look at people. This is a public observation which in theory the mother could share and therefore provide a basis for discussion. However, the health visitor at line 135 is not very direct about what the implication of her observation is and the client is therefore unable to provide any further information. At line 137 the health visitor started to retract her observation. This retraction enabled the mother at line 141 to repudiate the observation and explain any drift from the norm as an idiosyncrasy of the child. Ultimately, the potential health problem of the child's possible squint was not addressed. Despite the fact that health visitors do have professional knowledge of child development the health visitor did not go on to explore this mother's explanation of the child's behaviour. A further example of observation outside the norm demonstrates how the health visitor appears ready to accept the mother's explanation of the observation, perhaps as a way of maintaining a "friendly" relationship,

HVX5B (non-HVP):

Line 10 HV: She just seems a little bit warm to me still.

Line 11 C: Really?

Line 13 HV: Well, perhaps it's just that ....

Line 14 C: She's always quite hot anyway.

Line 15 HV: Is she? Oh, perhaps she"s ...

Line 16 C: She's got her coat on.

Line 17 HV: Hmm. [Goes on to talk to toddler]

In this example where, potentially, the child could be at risk with a raised temperature the health visitor retracts in favour of the mother's explanation. It appears that the client's receipt of the health visitor's observation as news (line 12) surprises the health visitor sufficiently to start withdrawing. The mother's final statement at line 16 seems to settle the matter, despite the possibility that the mother could be overdressing the baby.

These two examples are unusual in that in both cases the health visitor was trying to identify a problem about the baby based on their knowledge of the norm. To a degree the mothers are encourage d to participate by offering their own explanations of the observation. However, since the problems were not made explicit and the mother's explanations were not explored further by the health visitors the mothers explanations were apparently accepted and the children therefore left with conditions that potentially could have serious consequences.

Whilst in many previous examples the health visitor has been seen to maintain control of the sequence in these two examples control appears to be relinquished in favour of maintaining a "friendly" relationship with the client. It could also be perceived as abrogating professional responsibility

To summarise, health visitors from both areas used direct observations as a way of gathering data from the mother. In general, the observations related to the baby concerned and were based on the concept of normative need. To this extent, felt and expressed needs by the mothers were rejected. In some rare instances, the health visitors made observations which were potentially negative in the sense that the baby was not meeting the norm and in these cases it was found that the health visitors tended to retract their observation in favour of the mother's explanation; perhaps to maintain a friendly relationship and avoid confronting an uncomfortable situation.

Advice giving

A further major category identified from the interaction data was that of advice giving by the health visitors to the clients. This fell into two main sub-categories - solicited advice (i.e. requested by the client) and unsolicited advice (not requested by the client but initiated by the health visitor).

Advice giving was identified as any attempt on the part of the health visitor to impart information or instructions on a course of action to the client which would, as perceived by the health visitor, enable the client to meet a particular need or solve a problem which may have been identified by the client or perceived by the health visitor through the gathering of information. In a situation where client participation was prominent one could expect to find evidence of planning care and health action to meet the needs which the client had identified However, the delivery of advice was a prominent feature of both interactions from the HVP area and the non-HVP area indicating that the provision of advice is perceived by health visitors to be a major part of their role, regardless of the approach to care that has been adopted. The nature of the ways in which clients receive advice will be discussed below. In general, it can be seen that the function of advice giving does not allow for client participation as the overall prescriptive nature of the advice does not allow for exploration of clients perspectives or past experiences. The nature of the advice implies that the health visitor "knows best" about how the client should act and that any deviation from this would suggest that the client was not conforming to the expected norm.
On average, there were six advice giving sequences in each interaction from both HVP and non-HVP encounters, totalling about 350 examples.

Advice giving will be presented under the subcategories of solicited and unsolicited advice.

Solicited advice

Solicited advice was identified as advice which was requested by the client and given by the health visitor either in response to a direct question or in response to a need or problem which was described or alluded to by the client. Direct questioning by the client was the rarest method of initiating advice, accounting for only five per cent of all advice sequences. Both ways in which the client initiated advice, however, were always perceived by the health visitor as a legitimate opening for delivering the recommended

course of action. Thus, the advice given tended to be prescriptive with the implication that the client would carry out the advice given and conform with expert opinion. Even solicited advice was therefore identified as non-participatory for in all examples the health visitor went straight into a sequence of advice giving rather than exploring the problem further or identifying any explanations or solutions the client may have considered or setting any mutual goals to be achived by an agreed plan of action.

Examples of solicited advice were evident in both the HVP and non-HVP encounters in a similar ratio to unsolicited advice. In both areas unsolicited advice was offered, on average, ten times more often than solicited advice.

Solicited advice initiated by direct questioning from the client

As previously indicated, direct questioning by the client was an unusual feature of these encounters, accounting for only five per cent of all advice giving sequences. This was true for both the HVP and non-HVP interactions under study.

Whilst direct questioning by the client can be perceived as participation, the way in which it was handled by the health visitor suggests that in most cases the opportunity for exploring client's beliefs and explanations was lost by the health visitor who launched straight into an advice giving sequence. This may be illustrated by the following example from the non-process area, HVX7C:

> Line 207 C: I was going to ask you, when do you start giving babies cereals, because, err.... I've got no idea [laughs]
>
> Line 209 HV: Yes
>
> Line 210 C: I know she's only seven weeks now.
>
> Line 211 HV: Yeah, well the feeling from the experts and all the nutritionists and the professors and what not, is that it really is best if one leaves it until they're about four months old.
>
> Line 214 C: Really?

Line 215 HV: Yeah. See, there's no real reason for them to have anything else other than milk. Um, forever if you like.

Line 217 C: Really?

Line 218 HV: Especially breast milk [Yeah] because its, its exactly proportioned for them. Everything that's in it is just perfect for their growth and all the rest of it, but as they get older, um, obviously they need more milk to satisfy them, so therefore the volume gets too much.

[Explains need to change from sucking to chewing]

Line 239 HV cont'd: It's more a learning experience, rather than a nutritional experience, because they don't really need anything else other than milk. Er, but we say to start about four months and to go very easily to begin with, not a large amount just small, little tastes ...

Line 243 C: No, I won't give her ...

Line 244 HV: No, you'd be amazed at some babies. I'll tell you. Some are on more than three meals a day by the time they're six weeks [laughs]. But, um, you know from her point of view she, um, it is quite nice for her probably to have something other than milk.

Line 248 C: Yes.

This rather long sequence illustrates several features of advice giving. Firstly, the most notable feature is the ratio of health visitor talk to client talk. In all cases the health visitor talks much more than the client. This is, perhaps, self-evident through the very nature of giving advice but it precludes the client from presenting her perspective. In the example shown, the client has indicated at line 207 her ignorance of the weaning process. Although the health visitor acknowledges this at Line 209 simply by saying "Yes" the client then goes on to indicate that she does have at least *some* knowledge or understanding in relation to the age of commencement "I know she's only seven weeks now" suggesting that the mother appreciates the baby is too young at this stage to start on solid food. The health visitor, however, rather than further exploring

this mother's understanding and experience of weaning goes into an advice giving turn at line 211 based on expert opinion which leads into a much longer turn commencing at line 218. The health visitor dominates the sequence with the advice which has been requested by the client.

The second feature is that this domination of health visitor talk can be seen from the health visitor's perspective to be legitimate. The client has initiated the advice by asking a question. As the advice proceeds, the way in which the client receives the advice can be seen to legitimate further advice from the health visitor. This can be seen at lines 214 and 217 where the client responds "Really?". This questioning response suggests that the advice is news to the mother and, as such, gives the health visitor permission to deliver yet more information. Whilst specific pieces of factual information may well be new to the client, the health visitor makes the assumption that the fact that it is new will prompt action on the part of the client and that the client has no previous conception of the issue under consideration which may direct or bias the client's action. A third feature is that the client does indicate again that she does have some appreciation of the weaning process when at line 243 she begins to say that she will not give the baby, presumably, large amounts although she does not complete the sentence. This hint of some understanding of what weaning involves is ignored by the health visitor who reports, somewhat lightheartedly, on the apparent ignorance of some of the other mothers she works with. The sequence concludes by the health visitor giving the client "permission" to give the baby some solid food, to which the client agrees. However, this totally contradicts the advice given at the beginning of the sequence. One further feature of this sequence is the way in which advice is stereotyped. Since the health visitor has not explored this client's perspective she cannot give individualised advice and can therefore only provide the same advice as she gives to all her clients (presumably) based on expert opinion and normative need. This is supported by expressions from the health visitor such as "we leave it until they're about

four months" (line 212) and "we say to start about four months" (line 241) which suggests that this is the standard advice given to all parents.

In summary, the analysis of this sequence of advice initiated by a client question, identified the following features:
Health visitor talk dominated client talk, the perceived legitimation of health visitor domination by the client initiating the sequence and receiving the advice as news, evidence of client knowledge going unacknowledged by the health visitor and stereotyped advice.

These features were found among other advice giving sequences, both solicited and unsolicited, and are not seen as promoting participation by the client in the understanding of a problem and the approach to its solution. These features will be enlarged upon in relation to further illustrative examples of the advice giving sequence, for example :

HV3B (HVP):

Line152 C: What about fresh milk, when can he go on that?

Line 153 HV: I was going to come to that, yeah, now that you've come to that [yeah], no that's alright, from six months old the policy is in .... that you can go onto fresh milk. And what I normally suggest is that you use the ordinary milk thats the silver top or red top O.K.?

Line 159 C: Mm

Line 160 HV: Not the blue top because that's semi-skimmed. And I suggest to my Mums that they start it in the cereal, putting it in a cereal, baby rice or in with a rusk of some sort for the first time so that its just a small amount and see how the baby reacts to it. O.K.? Now, as regarding boiling, again I sort my Mums out. If it's todays milk [Mm], the milkman comes early enough, then you don't need t o boil it. Alright, O.K.?

Line 166 C: Right.

Line 167 HV: Thats because I happen to know you. Alright? There are some f amilies where I would say boil it, but I know your hygiene is good, O.K.? You're not going to contaminate a fresh bottle of milk basically. If its tomorrow...yesterdays milk, then yes, boil it, O.K., because its been in the fridge for 24 hours.

This sequence continues in the same vein for a further 20 lines - the health visitor prescribing the approach to introducing cows milk to the baby's diet and the client basically acequiescing with the advice offered. The sequence ends when the health visitor moves the topic onto cessation of breast feeding at line 196. The sequence again illustrates the dominance of health visitor talk over client talk. In this sequence the clients own understanding or experience of introducing fresh cow's milk to a babies diet is not explored at all. The health visitors advice is not only dominating it has evidence of a judgemental attitude ("I sort my Mums out" Line 164, "I know your hygiene is good" line168) and becomes increasingly confusing with regard to the treatment of milk . The health visitor clearly senses that it is legitimate for her to deliver her advice, again because the client initiated the sequence and also because the mother gives the impression she is concuring with the advice ("Mm" and "right") which encourages the health visitor to go on. Again, there is no guarantee that the client will act on the advice given as no mutual goals are set and there is no real checking of understanding. The advice is stereotyped - "I suggest to my Mums" (line 162) and "what I normally suggest" (line 156), giving the impression that all the families are the same when it comes to a developmental change such as introducing fresh cows milk.

There is no hard evidence in this sequence of the client having any knowledge of this issue, but since the health visitor did not attempt to facilitate this it would be difficult for the client who is in the position of receiving "expert advice" to put forward her own perspective of the problem. It is difficult to ascertain on this basis how many mothers quietly accept advice on topics about which they are already knowledgeable, although

when advice has been sought one assumes that the mother's knowledge base is perceived by her to be weak. An analysis of unsolicited advice suggests that mothers frequently *are* knowledgeable about aspects of child care but that this often goes unheeded by the health visitor.

Unsolicited Advice

Advice was perceived to be unsolicited when it was initiated by the health visitor in support of her own agenda. For example, where a health visitor had set out with the objective of discussing weaning then the mother was given advice on when and how to introduce the baby to solid food whether she asked for it or not. There were many more examples of unsolicited advice than solicited advice, suggesting that health visitors perceive themselves as advice-givers and as child care experts. In some cases, as previously suggested, there was evidence that the client was knowledgeable in the topic about which advice was being delivered but this was, in most cases, not taken account of by the health visitor. For example,

HV3A (HVP):

Line 218 HV: What's he like about cleaning his teeth? Have you started that yet?

Line 219C: Yes, I sometimes forget, A. often forgets so I try to get him in the habit of doing it whilst he's in the bath.

Line 220 HV: 'Cause this is the age, in fact, I mean at the moment you're on free dental treatment.

Line 222 C: Yes, that's right.

Line 223 HV: So you'll be having treatment anyway. But this is the sort of age to get them in the dentist. Not necessarily to have anything done, but to get them in the room so they are familiar with it. Obviously nobody is going to do anything at this age, they shouldn't need anything done.

Line 227 C: Right.

Line 228 HV: But if you, if they sort of come in with you then the room becomes familiar so that when they are a bit older, even four or five possibly, you see they may need to pop into a dentist at some point, they are familiar with the room.

Line 231 C: Yes.

Line 232 HV: So see what she's like.

In this sequence the health visitor has initiated the topic of dental health by asking a question at line 218. The client's response (line 219) suggests that she is aware of the value of dental hygiene and that she is trying to promote it within the family. At line 220 the health visitor proceeds to give her advice on attending the dentist. This sequence is embarked upon without establishing the client's knowledge of dental health, her usual attendence at the dentist or her experience of the dentist. The client does indicate that she has some appreciation of the dental service at line 222 which is not picked up by the health visitor - the expression "that's right" suggests that the health visitor is putting forward a suggestion which is already understood by the mother.

The example again illustrates the domination of health visitor talk over client talk and the apparent acquiescence of the client to "expert" advice despite the fact that she clearly was already attending to the issue of dental health.

A further example of unsolicited advice illustrates again how the mother receiving the advice as news legitimates further advice from the health visitor and, in this case, results in the mother changing her information to "fit" the health visitors advice. The health visitor initiates the sequence at line 161 by asking about the content of the baby's breakfast. After describing the cereal given the health visitor goes on:

HV1B (HVP area)

Line 170 HV: Yes, so there's a nice mixture there. And, er, she has a little egg?

Line 171 C: She has an egg every day, one egg every ...

Line 172 HV: I wouldn't give her an egg every day, I think thats too much, yes.

Line 173 C: Oh, I see.

Line 174 HV: I would suggest three a week.

Line 175 C: Three a week?

Line 176 HV: Yes, I don't think, um, its desirable to give her an egg every day.

Line 177 C: Right, there are days, you know odd days when I do tend to miss it [Mm]. But er, I had sort of formed the habit of giving it to her. We'll stop.

In this sequence of unsolicited advice the health visitor has initiated a topic which immediately prior to this sequence the client had quite clearly stated was not a problem to her (Line 159 "Eating is no problem at all"). However, the health visitor persisted in pursuing the topic and apparently hit on a problem. Bearing in mind that the enounter took place prior to the publicity surrounding Salmonella in eggs, the sequence demonstrates both the confusion that advice may arouse and the control that it can exert. Confusion occurs because the health visitor provides no rationale for her advice of three eggs per week, perhaps suggesting to the client that she could be harming her child in some way by giving more than three. In order not to 'lose face' as a mother the client then re-states her position to fit the advice (line 177) thereby demonstrating the control that the advice given can assert. The health visitor is again legitimated in giving the advice by the client's receipt of the advice as news. "Oh, I see" (line 173) suggests that the client was not previously aware of the amount of egg to be given and this is supported by the questioning "Three a week?" (line 175). Again, from this advice sequence the health visitor's assumption seems to be the client will act on the advice. Whilst the client appears to be compliant, without a clear rationale for the expected action and sharing her own beliefs and concerns about it, it seems unlikely that a behaviour which the client describes as "a habit" will change very dramatically, assumimg that it should.

One further example of unsolicited advice illustrates further the apparent refusal by the health visitor to accept the mother's expertise and to pursue her own line of advice

giving support to her own agenda. In this case, the mother was an experienced mother of three, the youngest of which the health visitor was concerned with on this visit, especially with regard to weaning. The health visitor initiates the topic:

HVX4C (non-HVP):

Line 18 HV: Have you started him on some solids?

Line 19 C: I tried him on Monday with some Farex or something.

[Discussion of baby's acceptance of cereal].

Line 38 HV: O.K. I bought you one of these leaflets ...can I just go through it with you? The first things here is really telling you, you don't have to have anything as posh as liquidisers and what have you, you can just put it just use ordinary seives and things to put it through for the baby, you know? ...if you do more than you need then you put them in the ice tray and freeze them as ice-cubes, but do remember to bring it back to the boil, so that you know its properly defrosted, O.K.? So in that way you could do some seasonal vegetables and put them it.

Line 45 C: Carrots and stuff?

Line 46 HV: Yes, because I do think that packets have their place, but I"ve never subscribed to the idea that is a good thing to get him used to eating beef and vegetables if as a family you don't eat beef.

Line 49 C: That's right. I did the others just vegetables, just to begin with.

Line 50 HV: And you used your own stuff?

Line 51 C: Mm

Line 52 HV: Yes, yes, I think you're quite right. So try him on that for starters.

At the opening of the topic the health visitor is already establishing that this, experienced mother has started to give solid food to the baby. Despite the mother's aparent experience this is not explored by the health visitor until towards the end of the sequence [line 50, "and you used your own stuff?"] when she has already given her advice. In this sequence the health visitor is urging the mother to prepare her own food for the baby without having established her previous experience, which it transpires

she has done in the past. In this case, the client's initial receipt of the advice may be misleading to the health visitor. At line 45 the client gives a questioning response which may suggest to the health visitor that the advice is news and therefore legitimates further advice. However, the client's next turn indicates to the health visitor that she has had experience of this process and by Line 52 the health visitor has terminated her advice giving and accepted the mother's experience. This sequence suggests that unsolicited advice can be "wasted" advice where the mother does have some expertise on the topic. It is possible that more time spent exploring the mother's previous experience and knowledge could potentially result in individualised rather than stereotyped advice and in mutual planning rather than prescription by the health visitor. It may also provide an opportunity for the health visitor to learn from the clients' experience.

Advice giving through the infant

In the same way that the infant was used to set the agenda, a further, less commonly occurring, feature of advice giving was that of directing the advice to the mother by speaking to the child. This characteristic of advice giving appeared to be idiosyncratic to three of the health visitors but was seen to be relevant to participation as the mother was not directly included. The technique appeared to be used when the health visitor needed to draw the mother's attention to a more negative aspect of her mothering skills or child's development. It can be seen to be a way of maintaining a friendly relationship whilst attempting to ensure that the mother is aware of the problem. Often this approach to advice giving was delivered in a light-hearted manner or even in "baby-talk". Sometimes this was followed up by a direct question to the mother, whilst on other occasions it was left for the mother to interpret the clues for herself.

For example, one health visitor from the non-process area visited a family where the baby had been born prematurely. The health visitor was concerned about the baby's weight gain. She initiates her advice on the topic in this way,

HV7D (non-HVP):

Line 84 HV: Does Mummy feed you, does she? Does your Mummy feed you? Is she giving you something extra, is she indeed? Is he coping with three ounces? [to client].

In the example shown the way in which this advice is initiated could undermine the mother's confidence, as it appears to be suggesting that the baby is not having enough milk. The sequence continues with a rather confused interaction in which amounts of milk required and given are established. A more direct approach to the mother would almost certainly have enabled a more rapid establishment of the current position and provided the client with the opportunity to solicit advice on feeding if she wished. A further example illustrates the point being made that, by initiating advice or highlighting a topic via the child, the health visitor loses opportunities for productive interaction with the mother.

In the following example, the health visitor has already established that the mother tries to brush the child's teeth but instead of discussing this further with the mother she directs her advice to child,

HVX2B (non-HVP):

Line 99 HV: I'm sure you won't have any teeth left by the time your Mummy has f inished with you, will you? You won't have any teeth left eh? She'll be polishing them away. Gosh, woe betide you if you get a little black one!

Line 105 C: That's right.

Line 106 HV: Right. Well, I can't see any squint there for him.

In this sequence the health visitor appears to be criticising the mother's brushing technique and the consequences of neglecting dental hygiene. Again, she does not establish with the client how she currently carries this out and whilst the client appears at line 105 to concur with the health visitor, the health visitor shifts topics at

her next turn so that the mother is left to fathom out for herself whether her dental care is adequate or not.

Whilst this approach to advice giving was not a major category it is significant in that it demonstrates a technique for *avoiding* direct participation with the client on a particular topic, especially where negative consequences may be involved.

Participation in care - a single case

The search for the deviant case which would support the claims being asserted that both solicited and unsolicited advice giving are health visitor dominated, prescriptive and stereotyped revealed one case in which the health visitor tended to explore the clients perspective of the problem rather than give advice. This case was perceived to illustrate some principles of client participation which will be highlighted. The case came from the non-HVP group.

HVX1A:

Line 1HV: I called round, D., this morning to find out how you got on last week and what changes you'd noticed.

Line 3 C: Well, um, I don't want him to go there.

Line 4 HV: You don't.

Line 5 C: Um, it's a lovely place, they've got fantastic toys.

Line 6 HV: Mm.

Line 7 C: But, it's obviously for problem children isn't it? And I'm a bit worried that it could influence him in the wrong way, I mean some of the children were O.K. but others sort of wanted to head-butt each other and I don't know whether I like the fact that he picks up everything at the moment.

Line 11HV: So you're worried that he might copy?

Line 12 C: So if one kiddie is going to hit.. yeah. Um, there's another child there who is 3 and a half and is still not potty trained so he's widdling on the floor everywhere, well we've just got him sorted out.

Line 15 HV: Mm.

Line 16 C: Er, I might go to the Wednesday afternoons now and again but I don't know so much if I would go.

Line 18 HV: If you'd want a place. Can you remember the reason for going in the first place, why I felt it would be helpful?

Line 20 C: Well, to try and routine him in a way.

Line 21 HV: Mm.

Line 22 C: Now that I did like. They, halfway through the afternoon they said right, everyone indoors. They had the little table out, and I mean we had to drag him in becuase he didn't want to go in.

Line 25 HV: Mm.

Line 26 C: But she was very good, the lady in charge, I mean, I was just sitting down with E. and she said "E., sit down" and in the end he realised he wasn't going to have any options and he did sit down and I liked that.

Line 29 HV: Mm.

Line 30 C: And I also liked the fact that they've got the little toy box and things like that.

Line 31 HV: I know, I know.

Line 32 C: It is lovely, but, I don't know whether I'd want him to go there two days a week, I don't you know, I'm sort of worried, that as I say, it might be the wrong influence on him in some respects.

Line 36 HV: Mm, mm.

Line 37 C: I mean, there was one woman there and she had a one year old and he toppled over and she sort of picked him up and she looked at him and she said "Oh well, they can't blame that on me" and I'm thinking, oh dear, you know, it

worried me a little bit. But some of them some of the kids were perfectly alright and he played quite well with some of them.

Line 41 HV: Mm, mm.

Line 42 C: But others they seemed to be a bit on the violent side.

Line 43 HV: Well different children have different problems.

Line 44 C: Yeah.

Line 45 HV: And it is there for a reason.

Line 46 C: For the problems, yeah.

Line 47 HV: Well, yes, call them what you like and I think B's reason for going there was for, well the families reason for going there, was to help you get him into a routine that is comfortable for all of you.

Line 50 C: Mm.

Line 51 HV: You were saying that in many ways B. was doing what he wanted to do, you were finding it difficult to get him to bed at bed-time and stay in bed, er, and you were finding it difficult getting him to sit up at the table and eat his meals at meal times and I felt that the structure that they provided you there.

Line 55 C: Yeah.

Line 56 HV: Would help you carry on the structure at home. It's very difficult, D., in isolation to do it. But when there are other children and other staff reinforcing what you are saying to B it makes it easier for you.

Line 59 C: Mm.

Line 60 HV: Did you talk about it with your husband?

Line 61 C: Yeah.

Line 62 HV: What did you say to him?

Line 63 C: As far as he's concerned its up to me really.

Line 64 HV: It's up to you.

Line 65 C: Yeah, but er .. we've sorted out the sleeping at night. We know what it is now.

The case is shown from the opening of the interaction and starts by illustrating the use of the specific statement for establishing the main objective of the visit (Line 1). This immediately alerts the client as to the health visitor's purpose and her response at Line 3 provides the basis for the remainder of the sequence. Notably, it is the client who does most of the talking in the remainder of the sequence. The health visitor accepts the client's view at Line 4 and from there on simply encourages the client to air her concerns about the family centre.

Rather than advising the client on why she should attend the family centre, the health visitor at Line 13 asks the client to recall the original rationale for attending, thereby eliciting the client's beliefs about, not only the reason for going, but its value to her son (Line 27) and her concerns about it (Line 33).
Clearly, the mother feels that by attending this centre she is being labelled as a "problem" which undermines her confidence as a mother. The health visitor, in recognising this, tries to explain her perspective of the situation not by advising the mother to continue attending but by recalling the mother's own explanation of her problems (Lines 51-54). This approach is conducive to the mother making her own decision; and the health visitor later says several times that it is "up to you". Whilst nothing is fully resolved in this sequence the mother later agrees that the child enjoyed the play group and to attend on a drop-in basis.

In summary, this sequence from a single case is presented to illustrate: Equity between health visitor talk and client talk, clear statement of visit objective, elicitation of client's beliefs and concerns, avoidance of prescriptive advice and the client is the decision maker.
These attributes, it was felt, can be recognised as client participation and are more likely to result in an action which has been mutually agreed between health visitor and client.

To summarise this section, the category of advice giving forms a substantial part of the interaction between health visitors and clients. Two main sub-categories were isolated - solicited advice (client initiated) and unsolicited advice (health visitor initiated). However, it was found in many instances, no matter how the advice was initiated it tended to be approached in the same way by the health visitor. There was a tendency on the part of the health visitor to put herself in the role of "expert" without acknowledging the possibility that the mother may have some expertise in the given area. Advice given tended to be in support of the health visitor's own agenda, prescriptive and stereotyped. These characteristics are not seen as being consistent with client participation. Remarkably, there were no distinguishing features in advice giving between the HVP and non-HVP areas. Finally, a further small category was identified in which advice was initiated by the health visitor through the baby. This was seen as technique for relationship-building or maintaining a relationship with the client.

A single case was presented to support the findings on advice giving which suggested that in one example there was an attempt to employ interaction techniques which encouraged client particpation. Interestingly, this case was from the non-process area.

Closures

The fourth major category identified from the data was that of closure. This was a process which occurred at or towards the end of the interaction and indicated to the participants that the encounter was drawing to a close. In all cases the closure was controlled by the health visitor, so that the encounter drew to an end when the health visitor perceived the agenda to have been completed or wished to terminate the interaction. Clients, in general, did not therefore have the opportunity to close the encounter either before the health visitor's agenda was complete nor after, thus averting participation in the closure of the interaction.

Closures fell into three sub-categories, these being:

Closing down the topic

Closing with false openings

Making a date.

Each sub-category will be described, with examples, in detail. The use of the HVP did not appear to influence the manner in which interactions were closed as there were no notable differences between the two areas in the way in which interactions were terminated.

Closing down the topic

This approach to closing the interaction was identified as a sequence in which the topic under discussion was brought to a close, without further elaboration by the health visitor or openings for the client to continue with the topic. Topics were invariably closed down by the health visitor, indicating her perception that the topic itself had been exhausted and that the overall agenda had been addressed. This type of sequence therefore left very little room for the client to either continue with the topic or open up a new area for discussion.

Features of this category of sequence included commonly used interactional comments such as "O.K." and "Right" which suggest that the topic is coming to a close. It is difficult to re-introduce the topic or introduce a new topic after these closing comments, as indicated by the following illustrations.

The first example of closing down topics comes from a case where the grandmother was the care-giver and her part of the interaction relates to the baby's mother, her daughter.

HVX1B (HVP)

Line 266 C: She's still on, Teresa still gives her a little feed in the morning and at night.

Line 267 HV: She's still on what? Teresa?

Line 268 C: She still gives her, yeah.

Line 269 HV: Good, oh good.

Line 270 C Line 271: She still feeds her at night and in the mornings.

Line 271 HV: Oh, you are lucky, Gemma! I don't think you need worry about her weight if she's got a healthy appetite and eating all lovely food.

Line 273 C: Yeah

Line 274 HV: She's lovely.

Line 275 C: Down the clinic, she said is she on the move? I said yes, she's all over the place now, you know, so she says that's why whe's using it all up, moving.

Line 277 HV: That's right. Good. O.K. I'll love you and leave you.

This sequence starts with the client (grandmother) opening the topic on the issue of the child's mother feeding the baby. This relates back to a previous sequence in which the grandmother is concerned about the baby's weight and her food intake. An interesting point emerges from the sequence shown. At no time is the word "breastfeeding" used by either particpant; although it is assumed from the context that it is breastfeeding which is being discussed. Indeed, at first the health visitor (Line 267) appears to have to clarify the topic being discussed. It seems likely that the fact that the care giver in this case is from an older generation where breastfeeding was not openly discussed, that she may have reservations about it in relationship to the baby's weight. For example, she may have felt that breast milk was not sufficient for a child of 10 months old. The health visitor at Line 269 surmises that breastfeeding is the topic and ratifies the situation ("Good, oh good"). the client confirms the state of affairs in her next turn (Line 270) and the health visitor responds to this in her next turn by attempting to reassure the grandmother that the baby's weight is not a concern. At Line 275 the grandmother tries to justify the baby's weight through her contact at the child health clinic where "expert" opinion had suggested that movement would account for it; thereby suggesting that she is not fully reassured. The health visitor's next and last turn at Line 277 confirms the clinic opinion and then closes the topic with the

comments "Good" and "O.K." and then finally states that she is leaving. This closure leaves unanswered questions such as what are this client's concerns about the baby's weight? And what are her beliefs about breast feeding? The health visitor's closure suggests that she (the health visitor) is happy that the grandmother is reassured and that further discussion is not appropriate. Analysis of the closure sequence suggests that, on the contrary, the grandmother may still have unresolved concerns and possible misconceptions which have not been explored.

A further example illustrates again the tendency for this type of closure to preclude client participation. In this case, the client had expressed some concern about the baby's cold, a valid concern given the baby's age of four months. In this example, the sequence starts with a closing comment to which the health visitor appears determined to adhere:

> HV3B (HVP)
>
> Line 507 HV: Right, shall we go and see some more babies, shall we? It's not bothering him too much, he's still quite cheerful.
>
> Line 509 C: Yeah, just yesterday he was terrible.
>
> Line 510 HV: Yes, he's still quite cheerful. You'll get better won't you? You'll get better. Eh?
>
> Line 511 C: I didn't but the heating on or anything, he'll get more stuffy won't he?
>
> Line 512 HV: He'll get a very stuffy nose. I'm not cold, I don't know about anybody else, but I'm fine. So, O.K. Bye-bye then young man, we'll see you again.

In this case the health visitor starts to close the interaction at Line 507 by referring to her next immediate action, further visiting. She does this through the baby, thereby reducing the possibilities of the mother opening up a new topic. However, the health visitor then continues her turn with what is presumably perceived as a reassuring comment on the baby's health. The mother at Line 509 seizes this opportunity to re-state her concern abou the child. The health visitor's next turn continues in a

reassuring tone and persists in talking through the baby so that the mother's participation is limited and closure can be achieved.

At Line 511, however, the client is not dissuaded from pursuing the topic and appears to be soliciting advice about how to manage the room temperature in relation to the baby's condition. The health visitor finally closes the encounter by affirming the mother's expectation that increasing the temperature will make the baby worse and by using her own body temperature as a guide to whether the heating should be increased or not. This effectively, from the health visitor's point of view, seems to bring the topic to an end and she ensures that no further discussion develops by using the closing comment "O.K." and saying good-bye to the baby, leaving no opening for the mother to express herself any further. Again, the encounter leaves unanswered questions which are pertinent to the health visitor's work with this family such as what were the mother's anxieties about the baby's health, for example when the mother said "he was terrible" what did she mean ?

By closing the topic with reassuring platitudes the health visitor has not only failed to elicit the client's participation in the interaction, but has overlooked an important aspect of her role as a health visitor, that of a health educator.

In a final example from this sub-category the client has been concerned about her own health as she was severely anaemic (Hb 6gm/litre) and felt permanently exhausted. The health visitor, having discussed the problem to some extent, begins the sequence by attempting to close the topic, indicated by the comment "O.K.":

HV7E (HVP)

Line 739 HV : O.K. Well, I'm sorry to hear about all your problems, it's a shame.

Line 740 C: Well, I'm glad that somebody ...

Line 741HV: ...is doing something ..

Line 742 C: ... spotted it really, because I thought I was just tired and I was making more fuss than other people, you know, because I really felt sort of dead at the end of the day.

Line 744 HV: Yes.

Line 745 C: And yet when I first had her I was fine, I was feeling quite well, I shouldn't be feeling so bad now I should have been feeling bad when she was waking up at night, you know?

Line 748 HV: Mm, mm. Right, O.K. I'll ask Sheila to keep in touch with you anyway; and um, I think Sally would like a few words with you. I'll see you soon.

Line 749 C: O.K.

At line 739 the health visitor starts the closing sequence with "O.K." indicating that closure is imminent. She acknowledges the client's problems and the client takes the opportunity to continue the topic. At Line 743 the woman is beginning to reveal her fears and beliefs about how she felt. The health visitor's next turn at Line 745 in fact encourages the client to say more about this. The client is clearly beginning to expose her confusion about the underlying cause of her tiredness at line 746. Despite the evidence that the client appears to be concerned about her health and has a need to explore her beliefs and worries in relation to this, the health visitor continues with her closure and effectively "blocks" any further discussion of this topic in her final turn at line 748. The extract again illustrates the failure on the health visitor's part to elicit participation from the client in terms of sharing concerns, exploring beliefs and misconceptions or setting any mutual goals for preventative action in the future. As can be seen from the line numbers, this encounter was a relatively long one and it could be that the health visitor felt that she had spent enough time on this particular visit. It worrying, however, to consider that in an interaction of this length the client was not able to express her concerns until termination was initiated. From the perspective of participation in an encounter, closure should ideally be negotiated to ensure that both

participant's agendas have been addressed. The type of closure identified in the examples described above, closing down topics, is not egalitarian since it assumes that the health visitor's agenda is also the client's agenda, which clearly may not be the case in the examples so far cited.

Closing with false openings

A second subcategory in the closures category was that of "closing with false openings". This subcategory was so called because on the one hand the health visitor was offering the client an opening for introducing her own agenda, but on the other hand, this occurred at the end of the interaction when the health visitor had already begun to make overtures towards closure. Thus, the health visitor was effectively controlling the client's participation in opening up new territory since the client was already aware that the health visitor was moving towards closure. The openings offered could not therefore be seen as genuine enquiries. A typical sequence in this subcategory would commence with a question from the health visitor such as "Is there anything else you wanted to ask me?"

However, the data suggest that, in most cases, even if the client did raise a new topic at this stage that the interaction still proceeded towards closure. An analysis of some examples of this subcategory of closure offers some explanation of how openings can, in fact, be false. The following sequence illustrates the point:

HV5E (HVP)

Line 666 HV: Right. Is there anything else then? No?

Line 667 C: No, he's a bit sweaty but I think its nothing abnormal.

Line 668 HV: Good. Right.

Line 669 C: Just gets a bit hot and bothered.

Line 670 HV: Right. O.K.? Fine.

In this example the health visitor commences the sequence with the closing down comment "Right". She then goes on to offer the client an opening which is immediately

blocked by giving the answer "No" herself. The client's first turn in this sequence demonstrates the controlling effect of this type of closure. Whilst the client initially conceded that she did not have anything else to discuss she then qualified this with a comment on a potential worry. However, as she was aware that the interaction was closing she "lightened" the concern by saying she did not think it abnormal for the baby to sweat, thereby reducing the chances of the topic opening up for further discussion. In her next turn (Line 668) the health visitor accepts the client's verdict of the baby's sweatiness and does not explore the matter any further. The client again refers to the baby being "hot and bothered" at Line 669 and the health visitor again at Line 670 accepts the mother's judgement of the situation that he is "just" hot and bothered - thereby suggesting that this is not a problem What appears to be happening here is that the health visitor, having completed her agenda, made overtures towards closure but at the same time offered the client an opening as a sign of perceived "good practise" - despite which the health visitor immediately blocked the opening. However, the mother is offered the chance to air her own concerns under false pretences as the health visitor evidently does not pick up that the client might, despite claiming to the contrary, in fact be concerned abou the baby's temperature. The client's turns in this sequence follow sequential implicativeness since she cannot raise genuine concern overtly when the health visitor has already suggested at Line 666 that she shouldn't have any. The opening is therefore controlled by the health visitor and fails to elicit the participation of the mother in the sense that this client was not able to discuss her own agenda any further.

A further example illustrates the way in which it is possible for the health visitor to control an opening by making it clear that closure is imminent:

HV5A (HVP)

Line 611 HV: Right. Well, we'll make a move. Was there anything else?

Line 612 C: No, I don't think so. I've mentioned about the rash which I wasn't worried about, but I thought I'd just mention it while you were here.

Line 614 HV: O.K.

Line 615 C: And I did want to know about the calamine.

Line 616 HV: Yeah, no that won't do her any harm either. Right. So we'll be going. Yes, I'll see you.

Again, the health visitor has made it quite plain at Line 611 that her intention is to close *before* offering the client an opening. Again, the client's turn can only proceed with "No" since she is aware that the health visitor is ready to finish. However, as in the previous example, the mother raised an issue which had been covered to some extent previously but the fact that she felt the necessity to raise it again suggests that it might have been an underlying worry, in spite of her statement to the contrary. However, she was not in a position to elaborate on the topic as the health visitor had already indicated that it would be inappropriate to introduce new material by her closure comments. The health visitor's next turn at Line 615 does nothing to disaffect the client of the impression that closure was imminent. At 616 the client raised an apparently minor issue which the health visitor briefly responded to at Line 617 before ensuring that closure was completed.

Clearly, client particpation has been obviated by the health visitor's need to close the encounter. However, questions are left unanswered such as what are the client's real concerns about the baby's rash? How will she cope with it or prevent it in the future? The health visitor could have elicited this information and used it to establish mutually agreed objectives if she had offered the client a genuine opportunity to express herself rather than controlling the closure of the interaction.

The final illustration confirms the impression that whilst wishing to display "good practise" by inviting the client's participation, that health visitors did in fact control the closure of the interaction.

HVX2C (non-HVP)

Line 298 HV: Right. Well, I think we've covered most things. Nothing else you're worried about?

Line 300 C: No, not at the moment now that he's alright on that milk.

Line 301 HV: Fine

Line 302 HV: Settled down on that.

Line 303 HV: Good. Right, we'll be on our way.

Line 304 C: Alright.

This sequence is typified by the use of the word "Right" to indicate that the encounter is coming to a close. The health visitor in this case actually verbalised her perception that the agenda had been covered. She then offered the client a false opening. By using the negative case she was "leading" the client into her response and thereby blocked client participation. However, whilst the client's first turn in the sequence followed the health visitor's turn sequentially by confirming that she did not have anything further to discuss, she then went on to raise the issue of milk and the child's diet; indicating that there had been a problem. The health visitor offered no further opportunity for the client to elaborate as it was perceived by the health visitor to be no longer a problem. Closure was completed at Line 303 by the health visitor and conceded at 304 by the client.

The three illustrations offered as examples of false openings suggest that health visitors control the closure of an interaction even when they are ostensibly opening it up to the client. Opportunities for clients to introduce new topics or go over topics already addressed are offered to clients by health visitors but these are in all cases offered at *the end of the interaction* when the health visitor has already made it obvious that the encounter must close. As discussed earlier under "agenda setting" there were no examples of such an opportunity being offered at the commencement of an interaction, suggesting that closure is perceived by health visitors to be appropriate when their own agenda has been addressed. It appears that openings are offered at the

end of an encounter as a sign of "good practise" but that health visitors in fact control these openings in such a way as to prevent the client from negotiating either the existing agenda or from introducing "any other business".

Closure through making a date

The third sub-category of closure identified was that of making a date. This was characterised by the encounter closing around a future meeting or contact between the health visitor and the client. This could be either a future home visit by the health visitor, a visit to the clinic by the client or telephone contact. The category was closely linked to the concept of follow up in the interview data as it suggested that the health visitor and client were to be in contact again to evaluate the effects of some advice ,such as the introduction of mixed feeding, or to carry out a developmentally appropriate screening procedure. The type of meeting and the timing was invariably suggested by the health visitor. There were no examples in the data of the client initiating negotiation of a future contact, either in terms of a time period or the type of contact. There were no notable differences between HVP and non-HVP interactions in the way that making a date was conducted.

As will be observed from the examples which follow, making a date was seen as further evidence of the health visitor's control over the interaction and the lack of client participation. During the interactions clients rarely refused to co-operate with a future contact as it was clearly seen as a way of ending the encounter. Clients were therefore seen to be agreeing to a future contact which they had neither initiated, demanded nor negotiated but this was perceived to be an acceptable way to close the encounter.

The first example of this process of closure is from the non-HVP group. The health visitor in this case is anxious to monitor the progress of a baby boy aged 3 weeks.

HVX4A (non-HVP)

Line 224 HV: Mrs L., mm, I'm at the surgery on Tuesday, O.K.?

Line 225 C: Mm, right.

Line 226 HV: Because I would like to see him once more before [Yes, yes] he comes down to the clinic on 24th September, just to see how things are going, alright?

Line 228 C: Yes, yes.

Line 229 HV: Super, good. Pack up all my wares here and I'll see you when you get down to either the surgery or the clinic, but I'd rather see you before if I can. Alright?

The example illustrates the characteristics previously outlined. At Line 224 the health visitor commenced closure by indicating to the client where the health visitor will be found at a future time. This moves the interaction from the present time to the future, suggesting that the present issues have been addressed and that closure is therefore imminent. At Line 225 the client apparently conceded with this proposal. However, at Line 226 the health visitor appeared to be compelled to justify the date she has made, perhaps feeling that to ensure compliance with the date she must make her intentions more plain. Again, the client acquiesced with the follow up plans. Finally, at Line 229 the health visitor appearsed happy that the date had been agreed and proceeded towards closing the encounter. She completed it by reiterating the type of contact expected with some indication of the expected time lapse. Throughout this sequence it is the health visitor who controlled both the when and where of the future contact. The date was made on the health visitors terms. In this particular case, the health visitor had visited the mother equipped with scales for weighing the baby at home. She was not offered this option again, despite having two other active children which may have made clinic visits difficult. Neither, on the other hand, did the mother suggest a home visit herself. The indication that the encounter was coming to a close seems to suggest a covert agreement to the date, even though the health visitor had not openly checked with the client that the type of contact and the timing were acceptable to her. Unfortunately, as with all these examples of making a date, it was not possible in this study to do a follow up interview to find out if dates were actually kept.

A further example substantiates the observation that health visitors control both the type of contact and the timing of it. It also supports the suggestion that clients appear to agree to the date as they are aware that the health visitor is moving towards closure.

HV9B (HVP)

Line 661 HV: Right, and his next check's not due until, er, eight months.

Line 662 C: Uh-uh.

Line 663 HV: So you'll get a card for that.

Line 664 C: Yeah.

Line 665 HV: Good. So you're just going along there for his immunisations and then for weighs you're coming down to me.

Line 667 C: Yes.

Line 668 HV: Lovely, good.

Line 669 C: Your fit .....

Line 670 HV: O.K. Well that besides, I know, I'll see you anyway in, er, on a Thursday when you come down and I'll come and see you again in six months, to talk about going onto more family foods and er, high protein foods and fish and meat and things. Lovely.

The health visitor commenced this closing sequence by indicating the timing of the next developmental assessment and reminding the mother that she will be informed of this through the post. The health visitor assumed that the mother wanted to take up this "check" - there was no negotiation over either the purpose of it or the necessity for it. At Lines 662 and 664 the client appeared to concede to the developmental check - she had no real choice since the health visitor was telling her what will happen rather than giving her the information and then asking her what she wanted to do. The health visitor's next turn at Line 665 is also an instruction rather than a date planned around the client's needs. Again the client agrees (Line 668). The health visitor then ensured that closure was completed by using the terms "lovely", "good" and "O.K." which suggest that everything had been covered and there were no further problems. The client

started to say something at 669 which was never completed as the health visitor brought the interaction to a close with two future contacts being suggested - the clinic in the near future and a home visit in 6 months time. In the case of the home visit the health visitor was already setting her agenda based on a child development model. The health visitor cannot predict what the family's needs will be in 6 months time and yet she was already "prescribing" the direction of this future interaction. She finally completed the sequence with the word "lovely" again suggesting that all is well and therefore nothing further to discuss.

The example again illustrates the lack of client participation in this closure sequence. The client's desires about future contacts were not elicited and although the client appeared to agree with the health visitors proposals there was no negotiation and no way of knowing whether the client actually complied. Again, the issue of normative need becomes apparent as does stereotyped practice. The health visitor is proposing a 6 monthly visit to address particular issues based on her knowledge of normal development at 8 months. She evidently visits all families at this stage and is quite clear about the items to be addressed. There is no indication that the health visitor will individualise her agenda for this future visit. The mother is therefore being refused the opportunity to negotiate the agenda for the next visit as she has quite clearly been told what the items for discussion will be.

There were many other examples of making a date which substantiate the suggestion that, when arranging a next contact, it is the health visitor who largely controls both the type of contact, the when and the where. In this study all the clients acquiesced, but due to the time factor in the research design it was not, unfortunately, possible to ascertain whether clients actually complied with the date arranged.

In summary, then, it is suggested that three types of approach to closing an interaction have been identified - closing topics, closure by false openings and making a date.

Illustrations from both HVP and non-HVP interactions have been offered to support the finding that in all cases health visitors maintain control over these closures. Some key word or comments on the part of the health visitor have been identified which seem to indicate that closure is imminent. These include words such as "Right", "O.K." and "Lovely". Such approaches to closure are not unique to health visitor-client interactions as they also form part of everyday conversation. These words appear to be sequential in nature in that clients perceive them as closure comments and therefore do not either open up new topics or reveal new problems or concerns. The clients also appear to be happy with dates suggested by the health visitors for future contacts as, again, these are perceived to be part of the closing sequence.

Conclusion

Overall, this analysis of the interactions between health visitors and clients has raised the concern that there is minimal evidence of clients actively participating in the encounter between a health visitor and a family with a child over one year in the sample studied. This is a crucial stage in a child's development with associated anxieties for parents. These anxieties and health related issues must be addressed by parents within the wider social context and within the context of their own lives. Their concerns will necessarily be unique to each family situation. The concept of participation between families and health professionals allows for these unique needs to be expressed, for health beliefs to be elicited, for collaborative decision making, and for health goals to be mutually agreed and evaluated on agreed criteria. The findings of this study suggest that clients are not given opportunities for participating in the interaction and that this can be largely explained by the approach of the health visitors to the encounter. It has been suggested that through subtle (and probably subconscious) means the health visitor controls the interactions in terms of setting the agenda, collecting and selecting information, giving advice and closing the encounter. These categories have been illustrated with a number of examples of sequences of conversations which demonstrate how one turn within a sequence implicates another.

This sequential implicativeness appears to directly influence the level of client participation because it is largely the health visitors who determine the nature and direction of the interaction. Thus, the health visitor can select from a number of strategies for organising the sequence. In order for the interaction to make some sense within a framework of child health which appears to be shared, the client's turns must follow the health visitor's in paired sequences. For example, the client must follow a question with an answer. One important aspect of the findings was that no notable differences in the way in which the interactions were constructed was found between health visitors practicing traditionally and those using the HVP. This suggests that a framework for practise such as the HVP, which in theory supports an individualised approach to care and active participation by clients, did not effectively change modes of interaction. The rationale for its use needs to be addressed alongside the need to develop a conceptual framework for health visiting which would enable practitioners to promote client participation.

Discussion of Findings

The current polemic on client participation which pervades the literature surrounding the future of health visiting (Fatchett, 1988, Goodwin, 1988, HVA 1988) would suggest that, in order to be effective in their health promotion role, health visitors should be able to involve clients in identifying their health needs and enable clients to negotiate ways of meeting their needs. The findings from this study suggest that there is a distinct lack of participation between clients and health visitors. This has been evidenced by the lack of congruence between health visitors and clients on their perceptions of home visits and by analysis of sequences of conversation between health visitors and clients during home visits. By using a comparative approach it also became clear that the HVP had a negligible effect on influencing client participation positively. This chapter will explore these findings further and offer some possible explanations.

Client participation and the HVP: Health visitors' perceptions of the HVP

Client participation has been advocated as an approach to the professional-client relationship over the last two decades in the medical literature (Haugh and Lavin 1987, Brody 1980, Strull et al 1984, Steele et al 1987) and increasingly in the nursing literature (Kim 1985, Brooking 1986, Brearley 1990). There is general agreement that by increasing the patient/client's involvement in decision making and care planning that satisfaction with care will increase (Haugh and Lavin 1987), that patient/client outcomes will improve (Roter 1977, Greenfield et al 1985) and that patients will experience an enhanced sense of well being (Lazare et al 1975). There appear to be some positive advantages in encouraging patient/client participation and the "consumers" do seem to desire a more participative role (Vertinsky et al 1975, Haugh and Lavin 1981, Kim 1985). These studies have implications for health visiting practice. The role of the health visitor, as outlined by the CETHV (1977), is as a facilitator of health enhancing activities and a health educator.

D'Onofrio (1980) has argued that the process of health education should involve the client's participation in "problem identification and prioritization, in the establishment of change objectives, and in the process of making decisions and how change will be accomplished." (p274). The health visitor's role in health promotion is being increasingly emphasised (Weir, 1991). It has been suggested that the health visitor of the future will become a specialist in health promotion, not just with the under fives but within the whole community (Ashton, 1990). From this perspective, participation with both individual clients and groups of people is clearly of profound importance. In order to identify health needs, to prevent illness and to promote positive health, health visitors need to develop the skills of facilitation, advocacy and communication. This is imperative if health visitors are to have a role in the future. Whilst the RCN (1989) and the HVA (1988) have embraced the concept of client participation there has been little evidence to date of the extent to which client participation is actively incorporated or encouraged in health visiting practice and, moreover, what the effect of a structured approach to practice such as the HVP might have on participation. This study aimed to explore in depth the phenomenon of client participation in health visiting by comparing the activities in practice of the small groups of health visitors, where one group had implemented the HVP with those of another group who were using a traditional approach.

Health Visitors perceptions of the HVP and its relationship to participation

An important aspect of this study was the exploration of the way in which the health visitors involved in the study perceived the concept of client participation and how this related to their perceptions of the Health Visiting Process (HVP). The health visitors were interviewed to gather this data and the findings raised some important issues concerned with the use of the HVP as a framework for practice and the relevance of client participation.

The Health Visiting Process has been developed from the Nursing Process as a method of providing a structured approach to care (Clark 1982, Hardy 1982, Marsden 1985, Colliety 1988, Candlin 1990). The authors cited all agree that the components of the Nursing Process (assessment of need, planning of care, implementation of care and evaluation of care) can be applied to health visiting. Integral to this approach to structuring care is the philosophy that care will become individualised rather than orientated around a series of tasks. Clients will thus become more involved in participating in their own care through negotiation of care planning, shared decision making and mutual objective setting, for example (Mauksch and David 1972, Lauri 1982, Binnie et al 1984, Colliety 1988). This systematic, collaborative approach to health visiting, will, it is proposed, lead to greater client satisfaction with care and more effective practice (Miller 1985, Richards and Lambert 1987, Colliety 1988). To date, there has been a dearth of evaluative research into the validity of these claims whilst a series of reports describes the implementation of the process approach into health visiting (Rogers 1982, Wilson and Cowan 1982, Clark 1982, Hendy 1985, McKay et al 1986) suggesting that it has become widely accepted as an approach to practice.

One of the aims of this study was to explore health visitors perceptions of the Health Visiting Process since the way in which it is perceived was seen as integral to the way in which it was applied to practice; especially in relation to client participation. To summarise the findings presented in chapter six, it was found that health visitors from

both groups held strong views about the HVP but that they differed in their philosophy. Most marked, was the finding that Health visitors who were using the HVP tended to perceive it as a management and teaching tool and a way of documenting care, whilst those using traditional methods tended towards a more conceptual perception of the HVP in that they saw it as a way of developing practice towards more individualised care and greater client participation. Additionally, following this part of the interview, concepts such as enabling and participation were explored and both groups of health visitors were found to hold positive views about these concepts. An interesting theme which emerged was the idea that health visitors "allow" clients to become self-helpers or reach their potential suggesting an element of control despite their enthusiasm for the general concept of participation. This substantiates the findings of Mayall and Foster (1990) who suggested that health visitors are more likely to be inteventionist in their approach than responsive.

Several questions emerge from these data. One is , why do health visitors who have implemented the HVP hold different perceptions of it to those health visitors who are using traditional methods, bearing in mind that there were no significant differences between the groups in terms of age, education or length of time in practice? The literature available on the HVP provides one possible explanation. Whilst there is much literature available on the Nursing Process, the literature on the HVP is limited both in quantity and scope. Much of what is available (Clark 1982, Hendy 1985, McKay et al 1986) tends to concentrate on the documentation aspect of the HVP. The concepts central to Health Visiting Practice (C.E.T.H.V. 1977) have not been developed on a significant scale within the HVP framework. Concurrent with this emphasis on changing documentation of care have been changes in the Health Service which have demanded that health visitors improve efficiency and demonstrate accountability (Griffiths 1984, Davies,1984).

Health visitors have the opportunity in quantitative terms to present evaluative data on their work to policy makers through the Korner Committee recommendations (Davies, 1984) This emphasis on quantity may have a detrimental effect on client participation. It is possible that opportunities for promoting the role of the health visitor in enabling people to take up immunisation and developmental assessment, for example, through resource allocation are being lost. This could be because health visitors are not able to demonstrate skills of assessment and negotiation within the current evaluative methods. These skills may then be undervalued and under-promoted. The current political climate demands cost-efficiency in health care and there are important implications for the future of health visiting if health visitors cannot demonstrate their value through qualitative evaluation of their own work as well as quantitative presentation of outcomes . It is not, perhaps, surprising that managers of health visiting have seized on the HVP as an approach to systematically documenting care, thus fulfilling some of the demands of the Health Service Policy. It was evident from this study that the HVP was implemented at the suggestion of Health Visitor Managers rather than from the health visitors themselves. This "top down" approach to change has been criticised by theorists such as Ottoway (1976) who suggest that the process of effective change should be engendered at field level by finding out the views of pratitioners, reflecting upon them and developing ideas until consensus can be achieved, an approach which embodies the principles of 'action research'. This would suggest that the health visitors using the HVP had possibly taken on board and internalised the management approach to HVP rather than their own perceptions. This would be supported by the apparent lack of involvement that health visitors reported experiencing in preparation for using the HVP and also by the evidence from the health visitors using traditional methods whose perceptions were not based on views imposed by management.

Further explanation may be provided by an exploration of the Nursing Process itself. Walton (1986) has comprehensively reviewed the literature on the Nursing Process. The main theme which emerges from her documentation is that the process of nursing can be systematically broken down into four stages (assessment, planning, implementation and evaluation) and the implication is that this is how nursing *should* be practiced. Henderson (1987) has criticised the Nursing Process on the grounds that by concentrating on this systematic, problem solving approach to nursing the profession has moved away from the holistic approach to the process of nursing expanded by Orlando (1961). Orlando's philosophy of nursing sees the nurse and the patient/client in dynamic interaction and that it is the process of this interaction through the reflective behaviour of the participants which can lead to therapeutic care. Henderson (1987) argues that the drive towards professionalisation led nurses in the 1970's to misinterpret Orlando's Process of Nursing and medicalise the approach by introducing terms such as nursing diagnosis and problem solving. This in turn, argues Henderson (1987), leads to a reductionist approach to care rather than a holistic approach. Donnelly (1987) has supported this view in her critique of Mauksch and David (1972). It could be argued, then, that extrapolation from general nursing to health visiting is invalid on the grounds that the nursing process itself is not a holistic approach and cannot therefore fully embrace concepts such as client participation. *Ipso facto*, the health visitors in this study who were urged to implement the HVP on the advice of their managers were accepting a reductionist approach to practice which does not necessarily take into account concepts such as client participation. It can be seen that this argument may be countered to some extent by the fact that health visitors using traditional methods of health vising held more accurate conceptual views of HVP. It may be assumed from their similar backgrounds that they were exposed to the same literature and are by definition part of the same health visiting culture. Why were the perceptions of health visitors using traditional methods towards HVP not equally reductionist?

One proposal is that health visiting lacks a universal conceptual framework for practice. Whilst some writers have attempted to put forward such a framework (Clark 1980, Bach 1987, Cowley 1988, Candlin 1990) all have based their proposals on existing models of nursing which themselves rely on the nursing process for their implementation and may not be valid for health visiting. It could be argued that health visitors need to return to the "drawing board" and surface from health visitors what the concepts basic to health visiting are and how they can guide practice (Dickoff and James 1968). It is also possible that in this study the health visitors using traditional methods of practice were articulating their personal perceptions of the Process of Health Visiting rather than the HVP per se, which would account for their more ideological approach. This line of arguement may also help to explain why, in spite of differing perceptions of HVP, both groups of health visitors held positive perceptions of concepts such as enabling and participation when probed further. It is possible that the health visitors were describing their own beliefs and values about health visiting practice which may be unrelated to the HVP. If this were the case then one might, not unreasonably, expect to find evidence of these beliefs in practice. This was clearly not the case as this study could demonstrate very little evidence of client participation. This would suggest that a serious gap exists between theory and practice.

Further explanation of influence of HVP on the client's and health visitor's perceptions of the visit and the interactions which took place may illuminate this finding.

Influence of HVP on congruence of health visitors and clients perceptions of a visit

From the data generated from the health visitors and clients perceptions of a visit two major findings emerged. These were that there was a low level of cogruence between health visitors and clients about their perceptions of the objectives of a visit, the health needs of the family, the plan of action and the follow-up discussed during a home visit and that using the HVP had no observable impact on improving agreement levels. Congruence between health visitors and clients was perceived by the researcher to be a

potential indicator of participation by clients. It is arguably more valid than client satisfaction, for example, since satisfaction may be achieveable without any significant participation . Satisfaction is not seen to be a useful measure as Speedling and Rose (1987) have indicated it takes no account of eventual outcome. Watson and Sim (1989) have argued that health visitors and clients can achieve high levels of satisfaction from a visit without complete agreement on the visit content. It was felt that high levels of agreement could only be achieved where clients were actively involved in the sharing of ideas, negotiation of care, collaborative decision making and mutual goal setting. These are facets which according to some writers are integral to the NP/HVP (Mauksch and David 1972, Lauri 1982, Binnie et al 1984, Colliety 1988) and yet implementation of the HVP had no observable impact on levels of congruence. Two obvious questions emerge: why were levels of agreement low despite the health visitors positive perceptions of concepts such as enablement and participation and why did the HVP have such a negligible effect?

To address the second question first, it would appear that if the argument presented so far is valid, then health visitors in this study did not perceive the HVP as a framework for actual practice but as a tool to facilitate documentation, teaching students and management of case loads. Therefore, even if it were poissible for the HVP as a framework for practice to enhance client participation it was not having this effect simply because it was not being put into practice. This is supported by Brooking's (1986) work with hospital nurses which found that the nursing process had no significant effect on patient or family participation in care.

Furthermore, a basic and fundamental stage of the HVP is assessment. A glance of the NP/HVP literature would suggest that accurate and effective assessment of client needs would demand client participation. If accurate assessment of need is achieved then one would reasonably expect congruence between health visitors and clients to be high. For example, some of the health visitors perceived part of the visit to be involved with

immunisation advice. None of the clients saw this as an objective or purpose for the visit. It became clear that health visitors defined objectives prior to a visit and that these determine the visit agenda, so that any notion of a needs-based assessment takes a low priority. The fact that clients may not share these objectives is not acknowledged.

However, an examination of the concept of assessment reveals that there may be an inadequacy in the way in which assessment is generally defined which may account for the low levels of agreement. This is discussed in full later in the chapter, but in brief it would seem that the term assessment is concerned with gathering information and making a judgement, processes which are not conducive to client participation.

To summarise, low levels of agreement between health visitors and clients in both the HVP and non-HVP groups, which were seen to be a measure of client participation, may be explained by the way in which health visitors generally perceive the HVP as a management tool rather than a framework for practice. An additional proposal is that the assessment stage of the HVP, where one might reasonably expect client needs to be elicited from the client, has been inadequately defined and operationalised. It thus provides little scope for client participation. Indeed, if Henderson's (1987) critique of the NP is valid, then it may be time to oust the term assessment from the Process altogether and search for a more client-centred, collaborative approach.

Congruence and Health Visitors perceptions of participation

Whilst the health visitors in this study generally held positive views on participation, this was not bo rne out either by the levels of agreement between health visitors and clients in either group or by the interactions which were analysed. Whilst the HVP did not appear to have any observable influence on client participation, it is possible that *both* groups were, in fact, practicing within a traditional framework of health visiting which does not make explicit or implicit claims about client participation. This

approach may not, therefore, take account of health visitors personal beliefs and values. The interview data revealed that both clients and health visitors perceptions of visits, in both groups, were focussed on issues related to child health. In this respect, health visitors and clients shared a frame of reference. Other studies support the idea that health visitors and mothers both focus on child health (Orr 1980, Ashley 1987, Colliety 1988, Watson and Sim 1989). However, agreement was lacking with respect to specific purposes and needs.

For example, in this study health visitors frequently stated agendas based on developmental assessment of the child which were not suppported by the mother's perception of the purpose of the visit or her perceived needs. For example, this was illustrated in one case where the client's response to her perception of need was totally in relation to her baby. However, when probed for any needs she felt had not been addressed during the visit she raised a problem she had with her own health, a positive blood test for a sexually transmitted disease which had important implications for her well-being and which was causing her a great deal of anxiety in terms of her relationship with her husband. Although she readily discussed this with the researcher during the interview following the health visitor's visit, she had not been aware that she could raise this type of issue with the Health Visitor. She described the role of the Health Visitor as someone who:
"bridges the knowledge between normal health procedures in children and sickness in childhood".

Previous work has suggested that Health Visitors are "family visitors", (Clark 1973) assessing the health needs of the whole family. More recent studies such as that carried out by Montgomery Robinson (1987) refute this claim and the current study would endorse the view that the health visitors observed were not assessing the health needs of the family but were basing their approach to the visit on the perceived developmental needs of the child. Returning to the earlier argument that health visiting practice is not

guided by a conceptual framework for care, it would appear from this analysis that there is, in fact, a basic framework - that of child development. However, whilst mothers do at least appear to share this frame of reference, it is in itself a reductionist approach to care since it reduces the focus of family care down to developmental stages of children under five years.

It could be argued that from this perspective on health visiting practice has not developed since the introduction of the NHS when the main aim of health visiting was to reduce infant mortality and to generally promote child health. Whilst it is indisputable that health visitors continue to have an important role in this area as argued by Hall (1990), the Principles for Practice (CETHV 1977) imply a much wider role. The Health Visitors Association supports this view and sees it as imperative that health visiting takes innovative steps to develop practice (Goodwin 1988, HVA 1988) as there is a real concern that health visiting could become submerged by other "growth areas" in nursing such as the Practice Nurse with the implementation of the NHS and Community Care Bill (Dept. of Health 1990).

This analysis does not in itself explain why participation in terms of agreement was consistently low whilst health visitors held positive views about the concepts of enablement and participation. It seems likely, given the lack of research based guidance for practice in the health visiting literature, that health visitors' beliefs and values about practice cannot be realised whilst they are constrained by a system which promotes child development and surveillance as an outcome rather than a process and imposes frameworks such as the HVP to measure and monitor the outcomes rather than develop practice. This view is supported by West (1989) in his study of innovation in health visiting. The barriers to innovation reported by health visitors in West's study include management policies and styles and organisational policies and procedures.

An interesting aspect of the analysis of health visitors and clients perceptions of a visit was that whilst, in this study, the levels of agreement were low, previous studies have reported different findings. Watson and Sim (1989), for example, conducted a survey of mothers and health visitors perceptions of home visits in an inner city area. The sample in Watson and Sim's (1989) study was slightly larger (n = 100) than the current study (n = 75) but methods were similar in that health visitors and clients were interviewed following a home visit to ascertain their perceptions of the purpose of the visit. Watson and Sim found that, in general, health visitors and clients agreed on the visit purpose. However, this difference in findings may be explained by the large sample in Watson and Sim's study who came from non-English speaking backgrounds. For example, 38% were Bengali. Not only did this necessitate the use of translators in some cases which may have distorted the findings, but culturally Bengali women are much more likely to be compliant with perceived representatives of authority. This is substantiated by Watson and Sim's finding that 100% of the Bengali women had found the visit helpful and 82% wanted more visits, compared with only 18% of other women in the study.

An additional criticism of Watson and Sim (1989) study is that a very quantitative approach was taken to the inteviews which may have led to important issues which mothers wished to discuss being missed. Perhaps most significantly, whilst the writers draw inferences about the level of agreement between health visitor and client during a home visit they cannot substantiate this with any observational or interaction data. The current study found *low* levels of agreement between health visitors and clients based on semi-structured interviews of their perceptions of the visits. These were substantiated by the detailed analysis of the recorded health visitor-client interactions. It is the purpose of the next section to explore these interactions further in terms of client participation and offer some explanations for the findings.

Discussion of the findings from the health visitor-client interaction

The analysis of the health visitor-client interactions presented in chapter seven suggest that when health visitors carry out a home visit there is little evidence that clients take an active role in establishing an agenda, in establishing or prioritising needs, planning care, negotiating decision making or in arranging future contact. In brief, the interactions which took place between health visitors and clients in this study did not demonstrate evidence of client participation. An important aspect of these findings was that the implementation of the HVP made no discernible difference to the way in which health visitors actually practiced. That is to say, the tenets of the HVP framework as proposed by Mauksch and David (1972), for example, that client participation is increased, could not be supported by the findings from this study. In an effort to understand and explain existing health visiting practice one must attempt to explore the low levels of agreement between health visitors and clients in the light of the organisation of health visitor-client talk and also search for explanatory theories of the health visitor-client interaction.

The overall picture which has emerged from this study is that, despite the implementation of a new framework for practice (the HVP) and despite positive views from health visitors of concepts such as enabling and participation, the health visitors initiated and controlled the visits to a very large extent. For example, it has been seen that health visitors could articulate their objectives to the researcher but that these objectives were not shared by the clients.This was evidenced by both the lack of congruence between health visitors and clients about the purpose of a visit and the fact that the interaction data revealed that the health visitors' objectives were not made apparent to the clients. A range of strategies were employed by the health visitor to indicate her purpose to the client which ranged from extremely vague statements such as "I'm the health visitor" to more specific statements such as "I said I would call last week to see how you are getting on with the feeding".

Evidently, these "agenda setting" comments as they have been labelled were not clear enough or relevant enough for the clients to be fully aware of the purpose of the health visitors visit. There was evidence from the inteview data which revealed that clients were much more likely to have vague recollections of the agenda such as "A general chat", "to check the baby's alright" than the health visitors who were more likely to articulate to the researcher a list of several specific objectives. As has been discussed, percentage agreement between health visitors and clients was very low. This would suggest that, right from the outset of a visit, the health visitor is the participant in control of the interaction and that such control is maintained by her through a process of gathering information, giving advice and closing the interaction. This finding supports the work of Sefi (1985) who also explored the health visitor-client interaction and also that of Montgomery-Robinson (1987) although she is much more tentative in her acknowledgement of the "hidden agenda" but talks of "orchestrated encounters". Warner (1984), on the other hand, argued that the health visitor-client interaction provided the medium for agreement on goals. An evaluation of Warner's study, however, reveals that it was in fact the health visitors goals that were being agreed not mutually negotiated goals. Thus, there is some consensus in the literature that health visitors control interactions with their clients.

This study has utilised the method of conversation analysis to throw further light on ways in which a health visitor-client talk is organised with particular reference to the concept of client participation. The research, like that of Montogmery Robinson (1987), did not focus on generating any new contributions to conversation analysis itself but has attempted to investigate further the nature of asymmetry in health visitor-client interactions and the implications this has for the outcome of the conversation in respect of the health visitor and client perceptions. It has also highlighted that whilst health visitors may be competent at structuring conversation to meet their own goals, clients are not so competent at organsi ng the encounter to meet their aims. In consequence, disjuncture and asymmetry inevitably arise, and this

limits the chances of client participation having priority. The analysis of the 62 conversations in this study revealed that encounters between health visitors and clients are structurally organised into four main domains. These being agenda setting, information gathering, advice giving and closure. Within these four main areas a number of sub-categories of interactive style have been identified the majority of which demonstrate the interactive dominance of the health visitor.

Agenda setting and Client Participation

The first domain which was identified within the health visitor-client interactions was agenda-setting. This can be described from the interaction data as the process in which the health visitor attempts to inform the client of the objectives for her visit. In theory, if client participation was encouraged one would expect to find evidence of the client's objectives being elicited so that an agreed agenda could emerge but no such evidence was found. Therefore, the process of agenda setting was very much under the health visitor's control. Interactional devices have been described which have been identified as the health visitors attempts at agenda setting. They range from broad questions such as "How are things?" to specific statements such as "I have come because I said last week I would check the baby's weight". It was more usual for the health visitors to employ the more elusive strategy than the specific one. Herein lies a paradox. When the health visitors were interviewed immediately following the visits they were able to clearly articulate to the researcher a number of objectives for the visit, whereas they appeared to be either unwilling or unable to be equally explicit with their clients. This suggests that whilst health visitors *did* have a clear list of items to work through, they were not sharing this openly with the client. This supports the existence of the "hidden agenda". Some authors have played down the suggestion that health visitors enter a household with a hidden agenda. For example, Montgomery Robinson (1987) seems to take the view that existing practice should not be compared with any concept of ideal practice. Indeed, she criticizes Sefi (1985) for doing so. However whilst Montgomery Robinson's (1987) data is highly suggestive of a hidden agenda she is

reluctant to acknowledge this fully for fear, perhaps, of denigrating health visiting practice. Sefi (1985), on the other hand, accepts that health visitors do apparently use controlling devices in their interactions with clients. Studies from a consumerist stance would also suggest that clients perceive them to have a hidden agenda (McIntosh 1986, Ashley 1987, Mayall and Foster 1990). Such an agenda would imply that health visitors visit clients with a series of "interventions" planned rather than responding to client needs. Indeed, a study by Luker and Chalmers (1990) describes how health visitors obtain their access to clients, both physically into their home and metaphorically into their lives to carry out what is described as "health visiting work". These authors describe a number of factors which affect health visitor access. A brief acknowledgment is made to the fact that access was facilitated and indeed very easy when the client requested the visit. When the health visitor acted *responsively* the visit was perceived to have been successful in terms of both access and outcome. All the other factors discussed by Luker and Chalmers appear to rely on the notion that the health visitor has "interventions" to carry out (i.e an agenda) and that these are made more difficult or facilitated by facts such as the client's previous experience of health visiting. The study was based on indepth interviews with 45 health visitors describing their access to clients. The findings were not collaborated by the clients perceptions of access nor by any interaction data to substantiate health visitors claims that they "focussed on the key need or problem as perceived by the client". This finding is not supported by the current study.

Overall, whilst Luker and Chalmers (1990) study provides some useful insights into the ways in which health visitors gain access to clients its fascination lies in the light it sheds on health visitors attitudes to home visits - that there are certain interventions to be achieved and health visitors have to work out strategies to achieve them. The concept of clients actively participating in this process of access is not openly acknowledged by the authors and neither are the implications of their study for future health visiting practice. For example, what are the implications for health visiting

becoming a totally responsive service? In the current study it is argued that the agenda, by definition sets the format for the remainder of the visit. Where the health visitor has made her objectives vague then the client will be unclear about the health visitor's purpose of the encounter as demonstrated by the low agreement between health visitors and clients on perceptions of a visit. On the other hand, where the health visitor tries to meet her own agenda without negotiation confusion is also likely to be the outcome. This seems to place the health visitors in a "no-win" situation. If they are too vague about their objectives the clients cannot participate because they are confused, if the health visitors are too rigid in their objectives then they can be accused of being interventionist. Since neither approach acknowledges client participation, what is it that prevents a health visitor from sharing her own agenda with the cleint and then eliciting the client's agenda and looking for mutually agreed ground?

Since there was so little evidence of client participation, despite the health visitors claims to endorse it, it seems probable that one has to turn to concepts of power and control in order to explain these data. Sefi (1985) has argued that the health visitors in her study were more orientated to be experts in child health than mother's friends. She has demonstrated this clearly with her analysis on advice giving. Robinson's (1982) earlier study of health visiting attempted to identify whether health visitors were 'problem orientated' or 'relationship orientated' had more inconclusive findings. The suggestions that they are more problem orientated may have been biased by the fact that the study was based on interviews with clients who did not attend clinic. Nevertheless, it supports the findings of others. Foster and Mayall (1990) describe how health visitors use a 'top down' approach to health education which is not acceptable to clients. They discuss the advantages of a dialogue approach to practice which would enhance client participation.

Such studies appear to support the claim that health visitors put themselves into a position of authority, particularly in relation to child rearing. This controlling attitude can be understood from the sociological perspective of power within the medical profession (Illich1977, Zola 1972). It is also arguable that if the HVP were being followed as advocated by its supporters (Clark 1985, Hendy, 1985) then the assessment phase would be needs-based and individualised, centering on the clients perceptions. However, it has been suggested that assessment is not adequately understood conceptually and that therefore it cannot address the clients felt needs. This inevitably leads to the process of planning care and promoting health being based on needs as perceived by the health visitor rather than the client.

Information gathering and Client Participation

In an ideal encounter between health visitor and client, particularly where the HVP has been implemented, one might reasonably expect to find the health visitor making an assessment of need based on the client's perceptions of their needs, be they felt or expressed (Bradshaw 1972). In the ideal encounter these needs would be elicited from the client and prioritised by the client. However, in this study it was found that there were low percentage agreements between the health visitor and client on perception of need and an analysis of the interactions explained this in terms of the way in which health visitors apparently established the clients' needs. In summary, the needs were established and prioritised according to the health visitors pre-planned agenda. Thus, client participation was minimal in the sense that needs were not elicited from the clients but derived from a complex process of information gathering based around the health visitors agenda. Information gathering is a broad term which covers a wide range of approaches to understanding the needs of the client as described in chapter seven. Overwhelmingly, it was observed that it was the information needs of the health visitor that were being addressed in order that advice may be duly given rather than the information needs of the client being ascertained and then either met or referred on to other agencies. The health visitor was perceived to be the participant in the role of

seeker of information, the one with the legitimate need to find out. This was demonstrated by the health visitors active role in asking questions as a method of collecting information and the client's passivity in responding to health visitors questions but rarely asking questions themselves. This is similar to the findings of other studies in participation, particularly Tuckett et al's study (1985) in which only 4% of patients asked overt questions. In the sense of information gathering, it can be seen that assessment as it has been described in much of the literature on NP/HVP (Clark 1985, Hendy 1985, Richard and Lambert 1987) *was* achieved but only within narrow parameters. This process of gathering information can be seen as a way for the health visitor to fulfill her own need of meeting the objectives of her visit and cannot therefore be seen as client-centred but rather as controlling. Again, this supports the findings of previous studies of consumer views of health visiting (McIntosh 1986, Ashley 1987, Foster and Mayall 1990)

The analysis of the data demonstrated that health visitors use a number of conversational approaches to gathering their information and that, in this study, the clients conformed with the health visitors by providing the information requested. There was no evidence of clients challenging the health visitors or asking health visitors to justify why they were there or why they needed the information. This differs from Tuckett et al's (1985) study in which they did find evidence of patients challenging and asking for justification from doctors, albeit minimally. The information in the current research was elicited from the clients in ways which prevented clients from challenging or offering their own assessment. For example, the question answer sequences have been described as interrogative. This approach puts the client in a submissive role whilst the health visitor is perceived to be the expert in need of data in order to reach a conclusion or 'diagnosis'. Indeed, the nursing process literature refers to the "nursing diagnosis" (Mauksch and David, 1972) and has been criticised by Henderson (1987) for its reductionist approach. In this sense, the HVP cannot facilitate client participation as the framework itself is inadequate for developing actual

practice. As has been indicated, a great deal of information was collected by health visitors during question/answer sequences but it was not clear how they were using this data to meet the needs of the clients. Indeed, it was felt that the health visitors could be gathering and storing the information as a way of maintaining their own integrity and maintaining themselves in the position of child health expert. Other approaches to gather information yielded similar interpretations of the health visitor-client encounter. Where comments were offered by health visitors following a question/answer this was largely completed in a style which precluded participation by the client. The client's response was either judged in a way which cast doubt on her expertise as a mother or prescriptive advice was often offered which did not allow for the client's interpretation of her perceived needs to be explored. Other commentary, of which there was very little evidence, invited the client to expand on her response thus clarifying the client's interpretation of the situation and allowing for more tailored care to be offered. A final approach to information gathering was that of making an observation in which the health visitor commented on some aspect of the child's development or behaviour in such a way as to elicit information from the client. The observations were perceived to be within a normative framework of child health so that mothers were made to feel they should adjust the information they were supplying to meet normative expectations. This again presumes that the health visitor is the child health expert, with the authority to cast judgement on the mother of a child who does not meet developmental norms or potentially to even initiate procedures which may result in the child being labelled as abnormal or the parents as deviant in some way. This again supports the feelings expressed by mothers in Foster and Mayall's (1990) study. It should be acknowledged that such an interpretation should be considered tentatively since the clients did not describe the health visitors' role in a negative light - indeed they were positive about the reassurance and support which they received. However, they did see the health visitor's role as exclusively concerned with child health thus casting them as an authority in this field and therefore having the *potential* to use this authority in a way which might seem detrimental to the client.

Other studies have certainly found evidence of this (McIntosh 1980, Ashley 1987). From this point of view it is conceivable that the clients apparent acquiescence in responding to questions lies in their need to comply with authority in order to be seen as "good" mothers and also to possibly hold back information which may have the opposite effect.

In summary, whilst information was provided by clients it was in response to questions and observations initiated by the health visitor and based on the health visitor's agenda. The information was therefore selective in that it only addressed the needs as perceived by the health visitor. The process of information gathering was constructed around the normative needs of the child and the health visitors role as child health expert was legitimated by the clients through their absence of challenging behaviour or active questioning. In other words, there was an absence of evidence of information sharing and negotiation of the clients needs as the health visitors had apparently pre-determined the structure of the visits, which precludes the concept of client participation.

Advice giving and client participation

It has been described how advice giving by health visitors was delivered either in response to a request by a client (solicited) or initiated by the health visitor (unsolicited). The analysis of the advice giving sequences revealed that health visitors dominated the sequence by the amount of health visitor talk compared to client talk. In some cases this domination could be perceived by the health visitor to be legitimate as the mother had initiated the request for advice. However, mothers' knowledge about topics on which advice was given was frequently ignored and advice was stereotyped. Overall, there was a distinct lack of client participation in the sequences. These findings from home visits to families with under children under one year support the findings of Sefi (1985) who found that advice giving was a strong feature of primary visits to new born babies. The giving of advice does appear to be an accepted feature of

health visiting practice, despite its connotations of a "top down" approach (Foster and Mayall 1990) and ultimate control over the interaction, thus precluding client participation. In Candlin's (1990) study of a potential model for health visiting based on Activities of Daily Living, in the context of care of the elderly, she emphasises the frequency of advice giving by health visitors to elderly persons. The study is based on an analysis of assessment forms using the ADL as criteria involving 90 clients. Candlin (1990) described 217 occasions on which advice was given compared to 129 where discussion took place. Since there was no direct observations of the assessments as they occured, it is open to the health visitors interpretation whether she describes her action as "advice" or "discussion" and it may well be that direct observation would reveal an even higher number of advice giving occasions. Candlin is not cri tical of the frequency with which health visitors appear to be giving advice, indeed she endorses the measuring of advice giving as an effective approach to evaluating health visitor practice. There is no qualitative analysis of the nature of the advice given nor whether it was in response to client's needs or in keeping with the criteria set out on the assessment form. Candlin's (1990) study would then appear to support the notion that advice giving is an acceptable approach to practice. Whilst not directly referring to advice giving, Luker and Chalmers (1990) refer to "interventions" being part of health visiting work, thus supporting further the idea that health visitors do have legitimate claims to entering a household and prescribing care or health promotion in a "top down" way. Whilst Luker and Chalmers (1990) are at pains to express the views of the health visitors who apparently recognise and value client autonomy the study as a whole reflects an interventionist stance.

Advice giving as a health visiting intervention thus appears to be supported by recent studies as a legitimate approach to health visiting. Clearly, in a profession where a major part of the practitioner's role is to promote the health of the individual and the family one might expect to find examples of advice being given. However, this emphasis is not reflected in the principles of health visiting (CFTHV, 1977), where the nearest

they come to advocating advice giving is "the stimulation of the awareness of health needs" and the "facilitation of health enhancing activities", neither of which can be described as directive or prescriptive.

It appears that health visitors have interpreted these principles, which in theory promote the concepts of facilitation and stimulation and thereby endorse client participation, in such a way as to embrace advice giving as a part of their role. The evidence from the current study certainly suggests that the health visitors observed used advice giving as a large part of their health visiting work and that clients, commonly responded positively. There is no way of evaluating from this study whether the advice was followed through, but the analysis of the sequences suggests that advice was often being prescribed in areas where the mother was already knowledgeable or taking action. Clearly, it is the way in which advice is delivered which is paramount here. Several cases were highlighted from the study where mothers did ask for advice, but analysis of the health visitors responses lead to the conclusion that even solicited advice was not participative since clients current beliefs, knowledge and experience were not elicited. Within a framework of client participation, the giving of advice would be deemed to be more acceptable if it was based on the client's felt need and made overt reference to the client's beliefs, knowledge and experience elicited by the health visitor rather than being delivered in an authoritarian and stereotyped manner. As with other domains highlighted in the findings, one interesting issue was that using the HVP made no difference to the way in which advice was given. There was no evidence that the HVP made advice giving more individualised or increased client participation. This again would suggest that the HVP, in isolation from a conceptual model, is an inadequate framework for promoting client participation.

Closure of interactions and Client Participation

The fourth domain which was identified as a feature of the health visitor-client interaction was the process of closing the interaction. In an ideal interaction driven by the concept of client participation one might, not unreasonably, expect to find evidence of clients drawing attention to their need to close the interaction (either because their needs have been fulfilled or because of practical considerations like meal times) and/or that health visitors would ensure that interactions were closed when the client's needs were addressed as fully as possible and mutual goals had been agreed. However, in this study, despite health visitors claims to support client participation, the opposite was found. The closure of interactions was exclusively controlled by the health visitors and even where an attempt was made to ensure that client needs had been addressed (e.g. "was there anything you wanted to ask me?") the analysis of these sequences has demonstrated how the health visitor organised and controlled the interaction into closure without having to address any further needs the client might identify. Thus, this particular approach may be seen as a way of paying "lip service" to "good practice" whilst maintaining control over the interaction. Clayton (1988) has argued that acknowledgement of the concept of client participation may, in practice, be a way of expropriating the client's power. She suggests that:

> "Techniques are adopted in the name of client participation which, in practice, have the covert aim of legitimising or extending the already strong position of existing power holders".
> (Clayton 1988 : 55)

The technique described in this study as "closing with false openings" may well be part of this covert activity, albeit unconscious on the part of the health visitor.

Montgomery - Robinson (1987) also identified "closings" as a category of health visitor-client talk in her study of primary home visits to mothers with new babies. The nature of the visits in Montgomery-Robinson's study may be different to those in the current study since it is unclear whether the mothers in her study were previously known to the health visitors. However, she does in fact produce similar findings to the current study.

She also identified techniques used by health visitors to indicate pre-closure and the terminal exchange (Schegloff and Sacks 1973) which can be interpreted as controlling although Montgomery-Robinson is cautious in her inference. She does, however, concede that mothers have difficulty in knowing when to expect the interaction to close because the interaction is based around the health visitor's agenda and not the client's perceived needs:

> "the lack of an explicit agenda, coupled with an understanding on the part of the mother that the health visitor has some plan or purpose, makes it very difficult for the mothers to predict when closing is likely to occur". (Montgomery-Robinson 1987 : 170)

Put alongside the previous discussion, this strongly suggests that interactions between health visitors and clients feature similar characteristics be they to mothers who have had little or no previous contact with the health visitor (as in the primary visits analysed by Montgomery-Robinson (1987) and also Sefi (1985)) or to mothers where the health visitor has established at least a basic relationship (as in the current study of visits to families with babies under 1 year). Coupled with the evidence from consumers of health visiting (MacIntosh 1986, Ashley 1987, Foster and Mayall 1990) there appears to be little doubt that there is a tendency in health visiting practice for health visitors to deny clients the opportunity to participate and for health visitors to maintain control.

Clayton's (1988) argument that the concept of client participation is underdeveloped and that it can be used to actually maintain the power of the professional may account for much of the lack of evidence for client participation in this study. However, whilst Clayton (1988) acknowledges that it is difficult to produce evidence of deliberate expropriation, she suggests that participation is often promoted "in areas where little or no power is located, or in ways which ensure the clients' voice can be easily ignored if unacceptable messages are received" (p.56). This, she suggests, is because the ground rules are set by the power holder, thus offering little opportunity for their authority to be challenged. It could be argued from the evidence presented in this study, culminating

in the control of closure of the interaction by the health visitor, that the whole process of the home visit is one in which the health visitor sets the ground rules and thereby controls the interaction.

The evidence from this study also suggests that the agenda was pre-set by the health visitor and not made explicit to the client and that the health visitors did not elicit the preferred agenda from their clients. Information was then collected by the health visitors which was in keeping with their own agenda. This then led into advice giving sequences which were again within the boundaries set by the health visitor's agenda and was not based on the needs as perceived by the clients. Finally, this overall agenda dictated when the interaction should close thereby pre-cluding the client's participation in any "unfinished" matters or the introduction of new topics.

As Clayton (1988) indicates, it is not obvious whether this approach is conscious or unconscious. One can only assume that since the health visitors in this study claimed to be supportive of the concept of participation then their actions must be unconscious and that it is the need for professional control and integrity which drives them rather than a need for personal power over the individual.

Critical Issues in relation to client participation

The evidence presented from this study, supported by previous research, demands that some explanation be offered for the way in which professionals take control of interactions and some possible perspectives be offered on how client participation could be promoted. It has been suggested that the process of assessment is inadequately defined, thereby making it difficult for health visitors to take a client centred approach. This will now be explored in more depth as a possible explanation.

Defining assessment

The term assessment is used throughout the nursing process literature. It is the first stage of the nursing process and implies an activity which is carried out in order to ascertain client needs so that effective planning to meet those needs may be reached. However, the literature is very sparse in providing nurses and health visitors with detailed information about what assessment actually means. It is perceived to be fundamental to the effective operationalisation of the nursing process that terms are defined and explored. However, it appears to be the case that there is pervasive and accepted understanding that assessment is recognised as information gathering. (See Crow, for example, 1979). The search for a general definition revealed that the Concise Oxford Dictionary (1964, 5th Edition) defines assessment soley in terms of taxation. The etymology of the term can be traced back to the Latin phrase for assistant judge (assessoreum) which became the English word assessor meaning one who sits as an adviser to a judge or magistrate or who estimates the value of assets for taxation purposes. Such a definition seems far removed from the way in which assessment is theoretically interpreted as part of the process of nursing.

Orr (1985) has suggested that assessment as part of the health visiting process should be considered from a number of perspectives by replacing the word assess with words such as "judge", "examine", "measure", "weigh up" and "put value on". Such terms, Orr (1985) suggests, highlight the reality that assessment is not a value-free activity but one to which the nurse or health visitor takes her own values and beliefs. To this extent, the health visitor as assessor is not that far removed from the judge's assistant. But as Orr (1985) and others (Muntz, 1988) have argued, health visitors should be aiming to free themselves of preconceived judgements and value laden perceptions. Certainly, if a structure for care such as the Health Visiting Process is to be effectively implemented then underlying tenets such as client participation are more likely to be promoted through a value-free approach. However, it seems that the term assessment is in itself

pre-empting the encounter between health visitor and client by its implication of judgement.

Other authors have viewed the assessment stage of the nursing process largely as an information gathering activity. Schaeffer (1974), for example, describes assessment as "the gathering of biopsychosocial data on the client". She goes on to suggest that it constitutes a search activity -

> "An explanation of conditions calling for action and the identification of possible alternatives and their consequences".

Schaeffer argues that the nursing process parallels the decision making process and as such she implies that the identification of needs can be compared to making a judgement in the decision making process. However, whilst Schaeffer suggests that it is the analysis of collected data which allows the nurse to arrive at her "nursing diagnosis" or judgement she does not elaborate on the process of analysis. For example, what cognitive and behavioural processes take place in order for the nurse and client to organise the data into needs that are meaningful to both client and nurse or health visitor?

Similarly, Lauri (1982) describes assessment as:

> "the gathering of data and the identification of the problem and on the basis of these, a nursing diagnosis is made".

Lauri perceives this to be a clear cut activity to be carried out in a systematic and purposeful way. She does not elaborate on the analytical aspect of assessment from which one assumes that Lauri does not consider the activity to be any more complex than gathering facts and identifying needs from the factual information available. Such an assumption does not allow for the subjective experience of either the client or the nurse.

McCarthy (1981) identifies some of the difficulties encountered when trying to align the term assessment with a process of nursing which takes as its centre point the individuality of the client. She argues that the nurse as an assessor is constantly processing information in order to make judgements so that actions may be carried out and evaluated. However, McCarthy highlights the fact that just *how* the information is processed is not specified by the nursing process model.

Clark (1985) has attempted to explain the nursing process in relation to health visiting. She described health visitors as being highly skilled in the activity of assessment which she defined as the "collecting of information about people and situations and comparing data collected with the 'norm' in order to detect 'deviations'".

Whilst Clark touches on how health visitors might analyse data (through constant comparison with the 'norm') this only addresses what Bradshaw (1972) has described as normative need. Clark does not enlarge on how other types of need described by Bradshaw such as felt, expressed or relative need can be identified. In so doing, she fails to present evidence for her assertion that health visitors are skilled in assessment, unless she means that they are skilled in collecting information. Processing the information to identify and explore a range of different needs requires higher level cognitive ability and communication skills than simply gathering the data. Clark does not elaborate how health visitors have demonstrated their skill in this area from which one can only conclude that little evidence is available.

To clarify, the nursing process literature is not helpful in determining what the activity of assessment really means. Whilst data collection appears to be an inherent part of assessment there is also an implication that processing this data involves judgement by the practitioner. This raises a dilemma for the practitioner. If the nurse or health visitor is practicing within a framework which is inherently client-centred, then such a process should preclude judgement on the part of the care giver. However, the very

nature of one stage of the process (assessment) both stems etymologically from the Latin word for judge and is interpreted as such within the nursing literature and by implication in nursing practice. The very term "assessment" present problems to the practitioner who is attempting to practice from a client centred perspective.

The Relevance of Professional Control

One explanation for health visitors taking control of the interactions with their clients would appear to lie within the sociological theory surrounding power and control in the medical profession.

Theorists such as Illich (1977) and Friedson (1970) suggest that knowledge is the key to medical power and that the medical profession jealously guards its expert knowledge as a means to preserving the power bestowed on medical people which gives them professional status, self-worth and ultimately control over society (Parsons 1951). There is no recognition of the knowledge or expertise held by patients/clients as it is medical knowledge which is deemed to be most valuable. The concept of patients meeting their doctors as experts has been explored in a study by Tucket et al (1985). Little evidence was found that doctors are skilled at eliciting or accepting the expertise of their patients.

Zola (1975) has argued that doctors are, in fact, agents of social control. The term social control refers to the system of regulation and sanctions with which the various norms and values of a particular society are enforced.

Zola (1972) has identified the institution of medicine as one which has a social control function. Zola argues that despite claims to objectivity and moral neutrality, doctors engage in an increasingly judgemental and moralizing position in relation to clients. Zola quotes Friedson (1970) in order to illustrate the means by which medicine can exercise this type of control:

> "The medical profession has first claim to jurisdiction over the label of illness and *anything* to which it may be attached, irrespective of its capacity to deal with it effectively".

Zola suggests four concrete ways in which this "attaching" process may be categorized. These four areas will be discussed and their potential relationship to health visiting reviewed.

Firstly, Zola has suggested that the 'practice of good medicine' has expanded to delve into areas of life not historically recognised as relevant when medicine was committed to an aetiological model of disease rather than a multi-casual one. Zola claims that concepts such as psychosomatics and holism have expanded enormously so that patients are required to divulge not only their physical symptoms, but symptoms of daily living, habits and worries. Zola sees these divulgences as intrusive and providing a perspective which "pushes the physician from beyond his office and the exercise of technical skills". The fact that many of these revelations on the part of the patient may put the physician in a preventative role brings even greater criticism from Zola:

> "In prevention the 'extension into life' becomes even deeper, since the very idea of primary prevention means getting there *before* the disease process even starts" (Zola 1972: 493)

Zola argues that through primary prevention the profession is exercising both moral and political control by making judgements about what is best for the patient and the overall good of society.

The second area in which Zola perceives medicine to have a controlling function is in its exclusive rights over certain technical procedures. By this, Zola is primarily referring to surgery and pharmacology. Zola sees some specialities taking medicine "far beyond concern with ordinary organic disease" and he cites plastic surgery and the prescription of mood altering drugs as examples of this.

A third area of concern is the access by medicine into what might be considered to be 'taboo' areas. Body processes have become medical specialities and Zola cites ageing

and pregnancy as examples of normal processes becoming medicalized. This is an area which has been explored in considerable depth by Illich (1977) who has suggested that not only has life become increasingly medicalized but that the ultimate effects of this process are iatrogenic.

The final area in which Zola perceives medical control to have percolated is in the "use of medical rhetoric and evidence in the arguments to advance any cause". Thus, Zola suggests that any proposal is immensely enhanced when it is expressed in the idiom of medical science. That many of the phrases and expressions in public usage are not expressed exclusively by professionals, only persuades Zola of the strength of his argument that the public takes their cues from a profession who have been increasingly extending their expertise into a social sphere. Here Zola refers to terminology such as "a healthy economy" or an "epidemic of activity". The potential consequences to a society where medicine is seen to have a controlling influence are, Zola suggests, infinite. Not only do medics perceive their role to be expanding further into life but the society they walk among comes to perceive itself in increasing need of medical help. Thus, health becomes of paramount value to a society and medicine finds itself in a position to exercise great control and influence over what we should and should not do to attain that 'paramount value'. This inevitably leads to the assertion that many medical decisions will not then be guided by technical expertise but by internal values.

The question thus arises, does Zola's position have any relevance to health visiting?

Historically, health visitors have been closely associated with the medical profession. Clearly, since one of the main functions of health visiting is recognised as being in primary prevention (CETHY, 1977) then health visitors could be seen, in Zola's terms, as being agents of social control. Equally, health visitors perceive their role to be much more than one of monitoring physical development and increasingly are involved in counselling (Burnard 1987) and assessing the psycho-social needs of clients. Health

visitors are clearly involved in the process of birth ante-natally and post-natally (Hennessy 1986) and also in the ageing process (Horsley 1987) and bereavement (While 1989). Thus, in Zola's terms, health visiting can be understood to be a method of social control since it permeates into aspects of life which may be considered 'normal' events. However, Zola's perceptions fail to take into account alternative views of health. Zola appears to view health from the perspective of the medical model (Townsend 1982) and to assume that the lay perspective shares his view. In other words, Zola assumes that the medical profession only has a role in the cure of established disease thus dismissing a range of more holistic approaches to health. For example, the World Health Organisation (1948) has defined health as not merely the absence of disease but "complete physical, mental and social well being" whilst more recent theorists such as Seedhouse (1986) see health in terms of people reaching their "biological and chosen potentials". These definitions tend towards a much broader understanding of the determinants of health and take into account peoples' subjective experiences of their lives as well as the more objective experience of illness. Health visitors have historically been aware of and involved in the wider perspectives of health care because the profession recognises that achieving health is much more than curing diseases. Health researchers such as Calnan (1984) have also shown that lay beliefs about health, whilst encompassing the absence of disease, also recognise the nature of a positive concept of health. Thus, rather than being agents of social control, it could be argued that health visitors are promoting and supporting existing norms and values within society. The possibility remains however, in the extent to which health visitors bring their personal or professional values into the encounter with a client. Muntz (1988) has suggested that by making their personal values more explicit, health visitors will encourage client participation. As Muntz points out that even subscribing to the idea that health visitors are "family visitors" is laden with value judgements about the nature of the family which may put single parents or childless couples at an immediate disadvantage and could be perceived as controlling. Understanding the broad and varied concepts of health held by both professionals and non-professionals and

recognition of the values brought into practice could enable health visitors to take on a more pro-active community orientated role as suggested by Drennan (1985) which would necessitate increasing client participation. This would entail a definite move away from a medical model of health as percieved by Zola (1972) and encourage health visitors to embrace a more holistic approach to health as promoted by authors such as Seedhouse (1986) and Weir (1991).

Robinson (1982) has argued that health visitors lay themselves open to criticism of being agents of social control by seeing their authority legitimated by the values of a society which prescribe a "common good", for example child health. As Robinson (1982) suggests, health visitors must not ignore individuals' motivations and preferences in pursuit of the "common good". By embracing the concept of client participation as central to health visiting practice, it is likely that health visiting will be perceived as a supportive and facilitative service rather than a controlling and authoritarian one.

However, this needs to be put into the context of existing ideology and values within the health visiting profession as a whole. There is a current move towards the so-called "New Public Health" (Public Health Alliance, 1988, Ashton 1990, Weir 1991) which whilst promoting the concept of client participation and the empowering of communities etc. may engender a new "common good" based on a social model of health. Health visitors may inadvertently use this ideology as a way of attempting to control public health measures such as immunisation and screening.

Implications for the education and practice of health visiting

This study has demonstrated that although health visitors are positive about the concept of client participation, there was very little evidence to support the application of the concept in practice. Since the HVA have made positive moves towards promoting client participation in health visiting (Goodwin 1988, HVA 1988) then there are certain issues pertaining to the education of health visitors and ultimately to their practice which need to be addressed. There has been little discussion in the health visiting literature of the concept of professional control or the potential problems which may ensue. This is curious given the growing literature from the consumerist perspective (MacIntosh 1986, Ashley 1987, Foster and Mayall 1990) which suggests that the amount of professional power being exerted is more than is, perhaps, desirable. However, there are a number of perspectives which need to be addressed in the education of health visitors in order to enhance their role in health promotion of the whole community and to avert the problems of professional control.

Communication skills

The huge literature on communication theory (Ley 1976, Argyle 1978, Ivey 1971, Hargie et al 1981) would suggest that using particular communication styles and techniques such as active listening and open questions enables the care-giver to reach an understanding of the patients or clients perspective of situation and therefore the interaction is more likely to be therapeutic. A great deal of research has been carried out, particularly in the medical field, to validate this claim. Studies have used outcome measures such as patient recall of information given doing medical consultatives (Ley 1972, Anderson 1979), patient satisfaction with the consultation (Carter et al 1982, Stewart 1984), compliance with medical treatment (Stewart 1984) and reduction in observable negative affects such as anxiety and pain (Hayward 1975, Wilson-Barnett 1978). These many and varied studies have used different outcome measures, different methodologies (for example, some have used direct observation of interactions whilst others have relied on reports by patients and doctors) and different operational

definitions of effective communication. Findings have therefore varied in their significance (for example patient satisfaction is a poor indicator as discussed earlier). However, there does appear to be a general consensus that "effective" or "meaningful" communication can enhance client outcomes although it is recognised that methodologically it is very difficult to correlate process data with outcomes (Pendleton 1983). In brief, the literature suggests that good communication between care giver and patient will lead to positive affects and potentially outcomes. Some studies in nursing have attempted to identify and describe communication in nursing practice. A study of nurses working on surgical wards by Macleod Clark (1982) found that there was very little evidence for effective communication and that, in fact, nurses tended to "block" communication with the patients by using closed or leading questions and missing cues offered by the patient. A later study into communication in health education by Macleod Clark et al (1987) revealed that following a short but intensive training course, nurses' communication skills could be marginally improved and that tentative links could be made with skills used and clients' success in stopping smoking. The evidence that good communication can lead to positive outcomes considered with the evidence that nurses are not, in general, very effective in communicating with patients/clients, has led those involved in the education of health visitors to start taking a positive approach to introducing communication skills into the curriculum (Lythgoe 1983, Burnard 1989, 1990), suggesting that the health visitor-client relationship is recognised as being important. However, further evaluative studies related to the role of communication skills in clients' participation in health promotion need to be conducted.

The current study did not analyse the interactions between health visitors and clients in terms of specific communication skills. This could be an area for further analysis in the future. Whilst the current study aimed to reach a more global understanding of the health visitor-client relationship in terms of client participation, it became apparent that a lack of communication skills may explain why there was so little evidence of

active client participation. However, communication skills alone do not develop or maintain a relationship. Certainly it could be argued that the health visitors in this study closed opportunities for participation by missing cues and using closed and leading questions, for example. However, analysis using conversation analysis suggests that the overall construction and organisation of the interaction is based around the perceived role of the health visitor as an expert in child health. Given this unbalanced power-relationship (health visitor as expert, client as passive receiver of knowledge) then the use of communication skills becomes important where the health visitor is achieving her own goals. As the perceived expert she has no real need to explore the client's perspective. This is bo rne out by Warner's (1984) study of health visitor client encounters in the clinic situation where the health visitor is perceived to use her skills in meeting her own goals. Communication skills can only be of therapeutic value where the framework for care demands that a client centred approach has priority. Whilst health visiting has paid lip-service to this approach, and the HVP is an example of this, there has been no real effort to develop a philosophy for health visiting which embraces the concepts of health, participation and relationship as central. When such a conceptual framework for practice is developed then relationship-centred practice which Robinson (1982) and Sefi (1985) have supported and which is alluded to throughout the health visiting literature might become reality in practice. The health visitors' role in health promotion both at individual and community levels could be developed within such a framework.In fact, paradoxical terms such as assessment may be replaced by terminology which highlights skills in negotiation and facilitation, thus abondonning the health visiting process framework For example, a humanistic approach to health visiting practice would promote communication between health visitor and client without the reductionist structure of health visiting process.

Theoretical perspectives to promote client participation in health visiting.

The next part of the discussion will suggest some theoretical perspectives which may inform health visiting practice in terms of client participation, which could be usefully incorporated into the education of health visitors and which may be helpful in the development of a conceptual framework for increasing participation in health visiting.

Steele et al (1987) have criticised the existing research on patient/client participation on the grounds that it has not been theory driven. Clayton (1988) has been critical of the dearth of literature developing the concept of client participation. Whilst the current study was exploratory in nature and not driven by any one theoretical perspective, it would seem useful in the light of the overall findings, to explore some existing theories which may help to guide health visiting practice and education in the future.

Locus of Control

According to Rotter's (1966) social learning theory individuals develop both a general and a specific expectancy about the determinants of the reinforcements they receive. Through a learning process individuals come to expect that certain outcomes are a result either of their own actions or of forces external to them. Locus of control simply refers to individuals beliefs about whether or not a contingency relationship exists between their behaviour and their reinforcements (outcomes). Individuals who tend to expect reinforcements to result from their own behaviour have been labelled "internals" and individuals who tend to expect reinforcements to relate to forces outside themselves are labelled "externals". But, as pointed out by Lewis, Morisky and Flyn (1978), the construct of locus of control represents a continuum of internality and externality rather than a dichotomy. Locus of control is developed over time and acquired through a series of many social learning experiences. However it has been argued that there is potential for change in a person's locus orientation (Arkelian 1980) through the introduction of new experiences.

The construct of locus of control has been perceived to be an important factor in the way in which an individual responds to health related advice, both in the area of compliance with treatment and response to health education. As such, the health locus of control has been widely tested for its realiability and validity in predicting and explaining health behaviours. In 1978 Wallston and Wallston published a review of over 40 studies which examined the predictive and explanatory power of the locus of control theory. They explored such areas as smoking behaviour, weight control and contraceptive use. In their conclusion, they suggest that there is evidence that the locus of control construct is relevant to the prediction of health behaviours, specifically information seeking, taking medication, keeping appointments, maintaining a diet and giving up smoking. Internals shows generally more positive behaviour in each of these areas. Some inconsistencies identified by the authors are put down to problems in measurement of locus of control and a failure on the part of some studies to consider other variables which modify the influence of locus of control such as social support and perceived costs and benefits of an action. Thus, in the earlier studies Rotter's (1966) Internal-External Scale was used whilst later a more specific Health Locus of Control Scale (HLCS) (Wallston et al 1978) was used neither of which Wallston and Wallston (1978) argue should be used in isolation.

More recent studies have addressed the construct of locus of control in relation to nursing and other health related professions Shillinger (1983) for example, argues that assessment of internality or externality can be a useful conceptual framework for planning nursing care. She suggests that "in case of internally orientated clients, the optimum approach may be that of self-care, while externally orientated clients may benefit from a more directive approach" (Shillinger 1983: 61). Shillinger also proposes a model for changing external orientation to internal. This is seen to be more congruent with preventive health behaviours. Shillinger does not, however, appear to question the ethics of this type of intervention. Littlefield and Adams (1987) explored the impact of locus of control on client participation by examining women giving birth

in an "alternative" birthing unit. An interesting finding from this study was that whilst the experience of the alternative perinatal care did not alter internality scores as measured by the HLCS, both internals and externals became more reliant on perceived powerful others (i.e. health staff) post-natally. The authors suggests that a combination of internality and reliance on powerful others could be a useful predictor of those most able to establish partnerships with health care providers. This has implications for application of the theory to health visiting.

Calnan (1988), on the other hand, suggests that the health locus of control model may be too general a concept and that health educators would benefit from concentrating on specific beliefs about control over behaviour - for example an individuals reasons for giving up smoking may not be determined by concern about health. This would suggest turning to the Health Belief Model (Becker and Maiman 1975), perhaps in conjunction with locus of control as suggested by King (1983).

Luker and Chalmers (1990) have considered the locus of control theory as an explanation for variation in health visitors gaining access to clients. They suggest that internally controlled clients may perceive themselves to be in command of their health and not in need of health visitors, whilst externally controlled individuals may consider input of a professional of little value since outside forces or chance are more likely to control their health. There is a need to consider these possibilities in relation to health visiting.

The implications of these studies for health visiting in relation to client participation are variable. It would appear, on the face of it, that an understanding of the locus of control construct and an ability to use skills and techniques of assessment to ascertain an individual's internality/externality, would enable the health visitor to both predict those clients who are most likely to participate in and feel in control of health-related behaviours and explain the behaviour of those clients who, for example, fail to attend

for clinic appointments regularly. However, there is nothing of note, to this researcher's knowledge, specifically in the health visiting literature, which would enable the health visitor or the student health visitor to put the theory into practice. Sophisticated communication skills would need to be developed if the health visitor were to attempt to utilise the theory and there would be some serious ethical decisions to be made regarding the reorientation of the external individual as proposed by Shillinger (1983). Moreover, studies such as those by Calnan (1988) indicate that the construct may not have the predictive or explanatory powers which have been assigned to it and that attention to more specific health beliefs may be of greater value.

Self-Efficacy

Self-Efficacy theory is derived from Bandura's (1977a) work in social learning theory. Social learning theory suggests that cognitive processes play a prominent role in the acquisition and retention of new behaviours. Motivation is seen in terms of the capacity to cognitively represent the future consequences of behaviour, thus behaviour is affected largely by the creation of expectations that the action will produce anticipated benefits or avert future difficulties.

Self-Efficacy theory, as proposed by Bandura (1977b), is a conceptual framework for analysing changes in behaviour. The theory postulates that people's perceptions of their capabilities affect how they behave, their level of motivation, their thought patterns and their emotional reactions in taxing situations. Self-efficacy theory provides one common mechanism through which people exercise influence over their own motivation and behaviour. Bandura suggests that people tend to avoid situations or activities they believe exceed their capabilities and they attempt behaviours which they feel capable of performing. Personal judgements of self-efficacy also determine the effort one will expend in the face of obstacles and how one will respond emotionally as well. The belief that one can influence an event tends to reduce uncertainty and anxiety. Despondency, on the other hand, can set in when one feels incapable of

influencing personally significant events. People respond to anxiety-inducing events in a number of ways. They can seek information in an effort to reduce uncertainty, acquire the skills necessary for achieving control, or try to avoid the situation altogether. In some situations, for example serious illness, the exercise of person control carries heavy responsibility and risk. Individuals may, therefore, be willing to relinquish personal control in order to "free themselves of the performances and hazards that the exercise of control entails" (Bandura 1882: 142). In so doing, they may settle for "proxy control" by entrusing a powerful other (e.g. a doctor) to act on their behalf.

When considering self-efficacy Bandura (1977b) suggests that an important distinction is made between perceived self-efficacy and outcome expectations. Perceived self-efficacy refers to peoples" judgements of their capabilities to execute given levels of performance whilst outcome expectations are judgements of the likely consequences that such behaviour will produce. This may refer, for example, to a clients' belief that following an immunisation programme will prevent disease in their child, but if the client's perceived self-efficacy in actually taking the child for a potentially painful or even harmful procedure is low then the benefits of the action will be overridden and the action not carried out.

The construct of self-efficacy has been subject to considerable empirical research in relation to its reliability in predicting and explaining health-related behaviour. O'Leary (1985) has published a comprehensive review of the literature which discusses the relevance of self-efficacy to health related behaviours. The nature of these studies (McIntyre et al 1983, Collett et al 1981, Di Clemente 1981) suggests that perceived self-efficacy can be changed or enhanced, thus enabling an individual to feel more efficacious in carrying out a behaviour. Indeed, Bandura (1977b) suggests four main ways in which self-efficacy is influenced. These are, Performance accomplishment in which Bandura which suggests that successes raise mastery expectations; repeated

failures lower them, particularly if the mishaps occur early in the course of events. Secondly, Vicarious experience in which Bandura (1977b) also suggests that self-efficacy is influenced by, not only personal experience, but by observation of the experience of others. Thirdly, Bandura (1977b) suggests that Verbal persuasion is the most easily available technique for changing self-efficacy but not necessarily the most effective. Finally, Emotional arousal, Bandura (1977b) suggests, may be useful in altering perceived self-efficacy in that stressful and taxing situations generally elicit emotional responses which, depending on the circumstances, might have informative value concerning personal competency. Therefore, emotional arousal is another source of information that can affect perceived self-efficacy. People rely partly on their state of psychological arousal in judging their anxiety and vulnerability to stress. Because high arousal usually inhibits performance, individuals are more likely to expect success when they are not beset by aversive arousal than if they are tense and agitated. Thus stress reduction, it is advocated by Bandura (1977b), should be attempted through helping people to develop mastery over aversive situations.

These four areas of influencing self-efficacy expectations clearly have implications for those involved with health related bahaviours, and particularly with assessing the desire for an increasing client participation in health care. Indeed, Steele et al (1987) have suggested that self-efficacy provides a useful theoretical framework within which to conduct research into patient participation and also to practice. They suggest that health professionals should assess their patient's self-efficacy perceptions and tailor treatment to those perceptions. The implications of this theory for the practice of health visiting are clear. Many situations faced by clients may be perceived to be stressful or taxing - for example infant feeding practices, immunisation or weight reduction. The evidence, as discussed in detail by O'Leary (1985), appears to suggest that performance of these type of health behaviours is related to perceived self-efficacy. It would seem, then, that an understanding of the concept and its application is important

if health visitors are to enable clients to feel more in control of their health. As Steele et al (1987) have suggested:

> 'Clinicians should therefore actively elicit and strive to understand their patient's perspectives and formulate approaches to treatment that are congruent with those perspectives" (Steele et al 1987: 20).

Taking the self-efficacy theory to its logical conclusion this may include acceptance that a client's perceived self-efficacy is too low to carry out a behaviour and also some helping strategies in trying to enhance the client's self-efficacy may be called for. This may mean working through an experience with them or giving them opportunities to observe others successfully carrying out the behaviour in conjunction with some verbal encouragement and anxiety reduction, through relaxation therapy for example.

Dennis (1987) identified three dimensions of client control using self-efficacy as a theoretical framework in a study which aimed to identify activities which gave clients a sense of control during hospitilization. These dimensions were: knowing and fulfilling the patient role, being involved in decision making and directing interpsonal and environmental components. This study concluded that hospitalized patients wanted to have control over the people and events that had an impact on their well-being and quality of life.

Extrapolating from Dennis' (1987) study, it would seem appropriate that clients should be fully involved in understanding the role of the health visitor and their own role as client. This would involve making it explicit that the health visitor recognises that the client has expertise rather than taking on the role of expert. Also health visitors could, within this theoretical framework, encourage client decision making and enable clients to take control over their environment and people around them. However, such a role by the health visitor again requires a knowledge of the concept of self-efficacy alongside considerable skill in eliciting perceived self-efficacy which Bandura (1977b) gives no guidance on. This again implies that skills in communication are imperative.

The author has considered elsewhere (Kendall, 1991) the hypothetical application of self-efficacy to health visiting practice as a way of enhancing client participation. However, the theory needs to be empirically tested for its validity in a practice situation in terms of its usefulness for identifying client needs, enhancing client participation and identifying client outcomes.

Health Beliefs

There are a number of approaches to the explanation and prediction of client's health behaviours which refer to their health beliefs. The most widely researched is probably the Health Belief Model (Becker and Maiman 1975), others include the Protection Motivation Theory (Prentice-Dunn and Rogers 1986) and the Health Action Model (Tones 1986). These models are derived from expectancy-value theory which suggests that behaviour is determined by the individual's weighing up the benefits of perceived outcomes against the perceived costs of processes involved.

The Health Belief Model itself is composed of a number of interrelated variables which explain an individuals perceived threat of disease and the likelihood of her taking preventative action. The model was developed by Becker and Maiman (1975) as a tool for explaining and predicting peoples' compliance with medical advice for preventative action. The main variables are perceived severity and susceptability to a given disease, which may be modified by demographic variables such as age and sex, cues for action such as advice from a health professional or direct experience of the given disease, - these variables will influence the perceived threat of the disease to the individual. Preventative action will then be based on the perceived threat but modified by perceived benefits of the preventive action versus perceived barriers. A great deal of research has investigated the validity of these variables in predicting health behaviours. By far the most reliable variables appear to be perceived benefits and barriers in relations to cervical screening (King 1987) and breast self examination (Calnan 1985). Critics of the HBM (e.g. Prentice-Dunn and Rogers 1986) have argued that it is disease orientated and

does not make provision for the promotion of positive well being, that it does not take account of the relationship of fear to preventative action and that the variables must be considered together as they do not have great validity if considered in isolation. King (1983) has argued that in order to use the HBM in practice it is necessary to intergrate the variables and to elicit from the clients what their health beliefs are in terms of severity and susceptibility to the disease and perceived benefits and barriers of the preventitive action. King (1983) suggests that the health professional should be able to modify the individuals health beliefs by dispelling misconceptions and clarifying information. It is recognised by King that this elicitation may involve considerable skill on the part of the practitioner.

The HBM is one approach to enhancing client participation since it take as its starting point the perceptions of the individual. It is applicable to health visiting in the sense that it attempts to predict preventative health behaviour but as Prentice-Dunn and Rogers (1986) have pointed out it does not address positive health action, which health visitors are being urged to be more involved in (WHO 1978, RCN 1989, HVA 1988). Its application demands interpersonal skills by the health visitor and inherently a relinquishment of control if the client's health beliefs are to be taken seriously and accepted as a valid contribution to the decision making process. This would require health visitors to become more aware of their personal beliefs and values, to be genuinely interested in the clients' perspectives and to develop skills in communication and facilitation.

Explanatory Models

Valuing clients' beliefs is also an inherent component of applying the concept of Explanatory Models (Katon and Kleinman 1980) to client participation in health visiting. The idea of Explanatory Models arises from the anthropological field and explores the way in which peoples from different cultural backgrounds explain and make sense of their health and illness experiences. Katon and Kleinman (1980) have

argued that, based on these cultural differences, lay participants in health may hold very different explanatory models to the health professional. These authors suggest that the explanatory models should be shared and explored between the client and the professional and that negotiation of health action should be based on a mutual understanding of the explanatory models. This again demands that the health visitor would have to elicit her client's explanatory model for a particular health action such as immunisation and be prepared to share her professional knowledge whilst valuing the client's contribution. This has been explored as an approach to client participation by Eisenthal et al (1983) who have claimed some success in developing a "negotiated approach to patienthood" in terms of patient outcome. Tucket et al (1985) used this approach as a theoretical framework to patient-doctor interactions and found that there was relatively little evidence of doctors meeting their patients as experts. They conclude that:

> "Doctors and patients did not manage to achieve a dialogue and so did not share or exchange ideas to a great degree" (Tucket et al 1985: 205)

This detailed study would suggest that the explanatory model framework is useful only when health professionals can relinquish their role as experts and accept the client as an equal. This clearly involves a shift in attitudes which has been alluded to in the literature since the questions posed by Szaz and Hollander (1956):

> "Do we take the patient's word for it (what is best) or do we place ourselves into the traditional parental role of knowing what is best?"
> (Szaz and Hollander 1956: 588).

Such an attitude shift appears to be taking place among academics judging by the theoretical literature available on client participation but this theory is taking time to filter into practice as evidenced by the current study and by those of Tucket et al 1985, Sefi 1985 and Montgomery-Robinson 1987.

In summary, a selection of theoretical frameworks have been presented which, it is postulated, may be helpful in promoting client participation in health visiting.

However, it is not being suggested that any one of these theories would be useful in isolation but rather as providing theoretical foundations for a conceptual framework for health visiting.which makes explicit the centrality of client participation to health promotion.It appears that much more emphasis needs to be placed on the integration of theory and practice in the education of health visitors, if frameworks such as those discussed above are to have validity in practice.

Conclusion of discussion

It has been argued by some (Haugh and Lavin 1981, Vertinsky et al 1974) that there has been a move away from the passive patient role towards a more active concept of the patient or client which, it is claimed, is accepted by doctors and lay persons alike. Such research would suggest that the Parsonian concept of the sick role (Parsons, 1951) and its incumbent implications for social control have been abandoned by the medical profession. This research, however, has been critiqued on the grounds that the scales for measuring desire for participation were inadequate and that the studies relied on reports by the respondents rather than actual observations. Whilst the ideological trends towards consumerism and participation can be traced back over the last two centuries (Steele et al 1987) this does not necessarily equate with what is happening in practice. Whilst a large amount of research has addressed increasing patient participation in the medical arena (Roter 1977, Greenfield et al 1985, Eisethal et al 1976, Tucket et al 1985)with varying levels of success, there has been very little previous exploration of participation by patients or clients in a nursing setting, particularly in the field of health promotion. Previous research has tended to concentrate on hospital in-patients (e.g. Brooking 1986). This current study has explored the concept of participation from a health visiting perspective with the focus on well clients in the community. This was seen to be of significance in terms of the health promotion role of the health visitor since changes at either individual or community level which would enhance health, can only be achieved where the client has perceived a need and negotiated ways of meeting that need. Whilst ideologically

nursing has embraced the concept of patient/client participation (RCN 1988, HVA 1988, Dept. of Health 1989) it was felt to be important to observe participation in practice. In this way an understanding of the state-of-the-art of client participation in health visiting could be reached. As Luker and Chalmers (1990) have suggested, there is a need to know more about the health visitor/client relationship. The fact that client participation does not appear to be a feature of health visiting practice in this study despite health visitor's claims to be positive about the concept, gives cause for concern. One possible explanation lies with the way in which the interaction is constructed by the health visitor and the client around the perception of the role of the health visitor as an authority on child health. The analysis of the interactions suggests that as an "expert" with specialist knowledge the health visitor sets the agenda for the visit, addresses the clients needs as she perceives them through a process of information gathering and advice giving and finally controls the close of the interaction. From this perspective, the health visitor can be compared with the physician as an agent of social control as described by Zola (1975). Robinson (1982) has cautioned against health visitors falling into this role. However, in this study health visitors appeared to be prescribing how parents should attend to their children's developmental and health needs with little reference to the client's perceptions of the situation. This clearly suggests a controlling approach which needs to be modified if client participation is to become an inherent concept in health visting practice. A selection of theoretical perspectives have been proposed which could reliably inform practice and which may help to promote client participation. In so doing, it is possible that the health promotion role of the health visitor could be developed beyond that of health advisor.

Conclusion of the Study

In concluding this study the key issues will be identified and their implications for future research and health visiting practice discussed.

This study has identified two major issues. The first is that among the health visitors in this study there was a striking absence of evidence for client participation in the one-to-one interaction. This was illustrated by the lack of congruence between health visitors and clients about the overall perceived objectives of a home visit, the perceived needs of the clients, the perceived plan of action and the perceived follow-up. These findings can to a large extent be explained by the analysis of encounters between the health visitors and clients which led to the identification of types of conversational sequences which were almost exclusively controlled by the health visitors.

The second major issue illuminated by this study is that the use of the Health Visiting Process as a framework for practice made no observable difference to levels of client participation. Caution must be taken in generalising from these findings as the two areas selected for the study could be seen as two case-studies and the findings may only be illustrative of health visiting as practised within these two specific areas. However, the study provides interesting data which may have implications for the future of health visiting and provide some indications for the direction of future research.

Health Visiting has reached an important turning point in its development. Whilst previous studies cited (Clark 1983, for example) have suggested that the health visitor is a family visitor, evidence from this study suggests that the health visitor's role remains largely orientated around the child health model. This is supported by findings from other research (Robinson, 1982, Sefi 1985, Montgomery-Robinson 1987). The need to move away from a model strongly driven by child health has been discussed by Fatchett (1990) within the context of Health Service policy. Fatchett argues that health visiting will be a "withering profession" if health visitors do not

respond to demographic change, to consumer demand and to policy changes. Thus, Fatchett sees the future of health visiting becoming more deeply rooted in the Primary Health Care team with health promotion responsibilities for the whole community as well as child health. Goodwin (1988) has also proposed new directions for health visiting, moving towards a community model of practice which encapsulates the concept of public health. Such an approach, Goodwin (1988) argues, requires that :

> "Whether in the individual or the group context, the content and focus of care must be issue-based and client-led: starting from what the users want rather than what we think they need." (Goodwin, 1988:8)

Such a participative approach to health visiting was discussed by the Health Visitor's Association in its document "Bridging the Gap" (HVA, 1988). This document also urges health visitors towards a community orientated approach and discusses the importance of client participation in this context. It suggests that:

> "Health Visitors and school nurses must actively pursue the breaking down of barriers in professional/client relationships and act as facilitators to enable clients to participate in their own health care" (HVA, 1988: 27)

It is clear from the current study that health visitors may not be ready to move towards this community based, participative practice. The health visitors in this research were not able to elicit client participation on an individual level. It is arguably an even more highly skilled task at a community level. Neither Fatchett (1990) nor Goodwin (1988) seriously address the issues surrounding the skills or knowledge required to practice in this new sphere.

Interestingly, in the current study, the implementation of a framework for practice (the Health Visiting Process) did not make any appreciable difference to health visitors eliciting such participation. This was despite one of the underlying tenets of the Health Visiting Process being that it promotes client participation (Maukch and David, 1982). It has been argued that the general lack of evidence for client participation may in part be explained by inadequacies with the operationalisation of the Health Visitng Process itself. The concept of assessment of need, for example, has been criticised by the author

for its underlying judgemental characteristics and the overall reductionist nature of the Health Visitng Process, as argued by Henderson (1987), is questionable. The Health Visiting Process in isolation does not appear to have beneficial effects for health visiting practice in terms of client participation. This would suggest that in order to move into the future health visitors not only need to re-orientate the direction of their work as advocated by Goodwin (1988) and Fatchett (1990), but also need to consider the development of a conceptual framework for practice which will enable concepts such as client participation to be made explicit. This indicates where future research might usefully be directed. Firstly, at a deductive level some existing theoretical perspectives on client participation such as Self-Efficacy (Bandura, 1977), Health Locus of Control (Wallston and Wallston, 1978) and the Health Belief Model (Becker and Maiman, 1975) could be explored in terms of their validity in health visiting practice. Current literature in health visiting reveals very scarce evidence of such theoretical applications to practice. Self-efficacy (Bandura, 1977) appears to have particular potential for application to health visiting practice and this has been explored at a hypothetical level by the author (Kendall, 1991). Steele et al (1987) have also recognised the relevance of this perspective to practice. However, future research should include studies to test the validity of the self-efficacy construct in the health visiting context. Alongside such studies promoting the concept of client participation, it is also necessary to assess the value of participation both to the client in terms of health outcomes and to the health visitor in terms of quality of care, job satisfaction and efficiency assessment. It would also seem reasonable within a changing climate of health visiting, that health visitors should engage in the process of standard setting to ensure that client participation is seen as intrinsic to practice. Such an approach would then indicate a need for evaluation of the standard.

At an inductive level, further research needs to be undertaken to surface the concepts basic to health visiting. Some of the evidence from the current study suggests that health visitors do have positive views towards client participation and it could be that they are constrained from putting these views into practice by the lack of a conceptual

framework. Some very recent work is being carried out at an inductive level and this may well provide some direction for health visiting (Cowley, 1991). There is clearly room for further inductive approaches to the development of a framework for health visiting. Complementary to this, an action research (Ottaway, 1976) approach to client participation would be a valuable way of assessing the process of change within health visiting practice.

Finally, it is imperative that whilst such theory building is in progress, that health visitors and students of health visiting debate the issues surrounding client participation and develop the skills of facilitation, negotiation and advocacy which are inherent in the concept. It is sterile to talk of the future direction of health visiting being community based and sympathetic to client participation until these skills are addressed.

In 1985 the Health Visitor's Association defined the health visitor as follows:

> "The health visitor, by promoting health and health policies, empowers people to take responsibility for their health as individuals, families and communities, and thereby helps to prevent and minimise the effects of disease, dysfunction and disability". (HVA, 1985)

The time has now come to ensure that this definition represents reality.

References

ANDERSON, J.	1979	Patient's recall of Information and its relation to the nature of the consultation. In: Research in Psychology and Medicine (Osborne et al Eds.) Academic Press, London
ARGYLE, M.	1978	The Psychology of Interpersonal Behaviour Penguin, Harmondsworth
ARKELIAN, M.	1980	An Assessment and Nursing Application of the Concept of Locus of Control. Advances in Nursing Science, 3, pp25-42
ARMSTRONG, D.	1988	Historical Origins of Health Behaviour In: Health Behaviour Research and Health Promotion (Anderson, R. et al Eds.) Oxford University Press, Oxford
ASHLEY, Y.	1987	Do health visitors really understand women's health needs? Unpub. Paper given at the International Primary Health Care Conference, Westminster, September 1987
ASHTON, J.	1990	The Health of Towns and Cities Health Visitor, 63,12,413-415
ATKINSON, J. M. & DREW, P.	1979	Order in Court : Organisation of Verbal Behaviour in Judicial Settings MacMillan, London
ATKINSON, J.M. & HERITAGE, J. (Eds.)	1984	Structures of Social Action Studies in Conversation Analysis Cambridge University Press
BACH, S.	1987	Evaluating the Health Visiting Process using a Model of Nursing. Health Visitor, Vol. 60, 9, pp 292-293
BAIN, D.J.G.	1977	Patient knowledge and the context of the consultation in general practice. Medical Education, 11, pp 347-350
BALDOCK, J. & PRIOR, D.	1987	Social Workers talking to clients - a study of verbal behaviour. Br. J. of Soc. Work 11, pp 19-38
BALES, R.F.	1950	Interaction Process Analysis Addison, Wesley, Mass.
BANDURA, A.	1977a	Social Learning Theory

Prentice-Hall, Englewood Cliffs, N.J.

BANDURA, A. 1977b Self-efficacy: Toward a Unifying Theory of Behavioural Change. Psychological Review, 84, 2, pp 191-215

BANDURA, A. 1982 Self-efficacy mechanism in human agency. Am. Psychol. 37, pp 122-147

BECKER, H. 1971 Problems of Inference and Proof in Participant Observation In: Filstead, W.J. (Ed.) Qualitative Methodology Markham Pub. Co. Chicago

BECKER, H. & GEER, B. 1971 Participant Observation and Interviewing: A comparison In: Filstead, W.J. (Ed.) Qualitative Methodology Markham Pub. Co. Chicago

BECKER, H. & GEER, B. 1971 Participant Observation and Interviewing: A rejoinder In: Filstead, W.J. (Ed) Qualitative Methodology Markham Pub. Co. Chicago

BECKER, M. & MAIMAN, L. 1975 Sociobehavioural determinants of compliance with health and medical care recommendations Medical Care, 13, 1, 10-24

BEDFORD, H. 1988 The Importance of Professional Advice in Advising high immunisation uptake Health Visitor, 61, 9, 286-287

BENSON, D. & HUGHS, J. 1983 The Perspective of Ethnomethodology Longman Group Ltd., Harlow

BINNIE, A. et al 1984 A Systematic Approach to Nursing Care Open University Press, Milton Keynes

BLOCH, D. 1975 Evaluation of Nursing Care in Terms of process and outcomes Nursing Research , 24, No. 4 pp. 256-263

BOSTOCK-HILL 1903 Annual Report of Medical Officer of Health to Warwickshire County Council Cited by Clark, J. 1973 (Op. cit.) p12

BRADSHAW, J. 1972 The Concept of Social Need New Society,30,640-643

BREARLY, S. 1989 Patient Participation: the Literature Scutari Press, Harrow.

BRODY, D.S.	1980	The Patient's role in Clinical Decision Making Annals of Internal Medicine, 93, 718-722
BROOKING, J.	1986	Patient and Family Participation in Nursing Care: the Development of a Nursing Process Measuring Scale. Unpub. Ph.D. Thesis, University of London
BROOKING, J.	1988	A Scale to measure use of the nursing process. Occasional paper 85, 3. Nursing Times 85, 15, 44-49
BROWNLEA, A.	1987	Participation: Myths, reality and prognosis Soc. Sci. Med. 25, 6, pp 605-614
BURNARD, P.	1987	The Health Visitor as a counsellor: a framework for interpersonal skills Health Visitor 60, 8, 269
BURNARD, P.	1990	Counselling Attitudes among Health Visiting Students Health Visitor, 63,11,389-390
BURNARD, P. & CHAPMAN, C.	1988	Professional and Ethical Issues in Nursing. John Wiley and Sons, Chichester
BYRNE, P. & LONG, B.	1976	Doctors Talking to Patients. HMSO, London
CALNAN, M.	1985	Women's Beliefs about Breast Cancer and i its Control Health Education Journal,44,2,75-78
CALNAN, M.	1988	The Health Locus of Control. An Empirical Test Health Promotion, 2, 4, 323-330
CANDLIN S.	1990	The Health Visiting Process and Older People Health Visitor, 63, 8, 271-274
CARTER, W., INUI, T. et al	1982	Outcome based doctor-patient interaction analysis: ii Identifying effective provider and patient behaviour. Medical Care,20,550-566
CASTELDINE, G.	1981	The Nursing Process in the United Kingdom J. of Ad. Nursing 6, 6, 503-514

CARPENTER, R.	1988	Preventing unexpected infant deaths by giving extra care to high risk infants Health Visitor, 61, 8, 238-240
CARPENTER, R.G. & EMERY, J.L.	1974	Identification and follow up of Infants at Risk of Sudden Death in Infancy Nature 250, p. 729
CARPENTER, R.G. & EMERY, J.L.	1977	Final Results Nature 268, p.724
CASSILETH, B. et al	1980	Information and particpation preferences among cancer patients Annals of Int. Med., 92, 832-836
CHALMERS, K. & KRISTJANSON, L.	1987	Describing and Analysing Community Health Practice Unpub. paper presented at International Nursing Research Congress, Edinburgh 29-31 July, 1987
CHAPMAN, C.	1980	Accountability for the Advancement of Nursing In: Accountability in Nursing, the Report of a Seminar for the Fellows of the Royal College of Nursing, RCN, London
CHAVASSE J.	1981	From Task Assignment to Patient Allocation:a Change Evaluation. J. of Ad. Nursing, 6,2, 137
CHENITZ, W.C. & SWANSON, J.M.	1984	Surfacing Nursing Process: a method for generating nursing theory from practice J. of Adv. Nursing 9, 205-215
CITRON, M.J.	1977	Attitudes of Nurses regarding the patient's role in decision-making process and their implications for nursing education PhD Thesis, University of Pittsburgh
CLARK, J.	1973	A Family Visitor Royal College of Nursing, London
CLARK, J.	1980	A framework for health visiting: A systems approach Part 1: Application of systems theory to Health Visiting Health Visitor, Oct. Vol. 53, pp 418-419
CLARK, J.	1980	Part 2: The Nature of Health Visiting Activity Health Visitor Nov. Vol. 53, pp 487-489

CLARK, J.	1980	Part 3: The Environment and Time Dimension Health Visitor Dec. Vol. 53, pp 533-535
CLARK, J.	1981	What do Health Visitors Do? Royal College of Nursing, London
CLARK, J.	1982	That Uncertain knock on the door Nursing Mirror 30.6.82, pp 33-35
CLARK, J.	1982	A Way to get Organised Nursing Times Community Outlook ,13 October, pp 287-297
CLARK, J.	1983	Evaluating Health Visiting Practice Health Visitor, Vol. 56, 6, pp 205-208
CLARK, J.	1984	Recording Health Visitor/Client Interaction in home visits Health Visitor, 75, pp 5-8
CLARK, J.	1985	Delivering the Goods Nursing Times Community Outlook, January, pp 23-24, 26-28
CLARK, J.	1985	The Process of Health Visiting Unpublished PhD Thesis, Polytechnic of the South Bank
CLARK, J.	1985	Putting the Patient First. Nursing Times, 13 Feb., p. 22
CLIFTON, J.	1981	Social Workers talking to Clients - A Comment Br. J. of Soc. Work 11, 39-42
CLAYTON , S.	1988	Patient Participation: An Undeveloped Concept. J. of Royal Society of Health, 2, 55-58
COLLETT, I.G.; SUPRICK, J. & RIZZO, A.A.	1981	An analysis of relapse determinants for treated smokers Paper presented at the meeting of the Am. Psychol. Assocn., L.A., Calif. Cited by O'Leary 1985 (Op. cit)
COLLIETY, P.	1988	An Evaluation of the Health Visiting Process (Pt. 1) Senior Nurse, 8, 12, 13-16
CONCISE OXFORD ENGLISH DICTIONARY	1964	Fifth Edition, Oxford University Press
COULTON, C.J.; DUNKLE, R.E.; GOOD, R.A. & MACKINTOSH, J.	1982	Discharge Planning and Decision Making Health and Social Work 7, 4, 253-261

COUNCIL for EDUCATION & TRAINING OF HEALTH VISITORS	1967	The Function of the Health Visitor Cited by Robinson, J. 1982 (op. cit)
COUNCIL for EDUCATION & TRAINING OF HEALTH VISITORS	1977	An Investigation into the Principles of Health Visiting Council for Education and Training of Health Visitors, London.
COWLEY S.	1988	In Search of a Model for Health Visiting Health Visitor, 5,61, 149-151
CROW, J.	1979	Assessment. In: The Nursing Process (Kratz C. Ed.) Balliere Tindall, London
CULLEN, C.	1983	Residents Development Project Final Report to Dept. of Health and Social Security Cited by Walton 1986 (Op. cit.)
DAVIES, P.	1984	Korner: Implications for Community Nursing In: Current Perspectives in Health Computing Kostrewski B. (Ed.) Cambridge University Press
DE LA CUESTA, A.C.	1979	The Nursing Process: from theory to implementation Unpub. MSc Thesis, University of London
DENNIS, K.	1987	Dimensions of Client Control Nursing Research 36, 3, 151-156
DENZIN, N.K.	1978	The Research Act (2nd Ed.) McGraw Hill, New York
DEPT. of HEALTH & SOC. SECURITY	1956	An Inquiry into Health Visiting (Jameson Report) HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1968	Report of the Committee on Local Authority and Allied Personal Social Services. Cmnd. 3703 (Chairman: F. Seebohm) HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1969	Scottish Home and Health Dept. and Welsh Office Report of the Working Party on Management Structure in the Local Authority Nursing Service (Chairman : E.L. Maysham) HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1972	Report of the Committee on Nursing Cmnd. 5115, (Chairman: Prof. A. Briggs) HMSO, London

DEPT. of HEALTH & SOC. SECURITY, DES & WELSH OFFICE	1976	Fit for the Future. Report of the Committee on Child Health Services Cmnd. 6684 (Chairman : Prof. S.D.M Court) HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1978	Report of the Committee of Enquiry into the Education of Handicapped Children and Young People (Chairman: Mrs. H.M. Warnock) HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1979	Royal Commission on the National Health Service Cmnd. 7615, HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1980	Inequalities in Health. Report of a Research Working Group. (Chairman : Sir Douglas Black) HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1984a	Health Services Management Implementations of the National Health Service Management Inquiry Report HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1984b	Immunisation Against Infectious Disease HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1986a	Report of the Community Nursing Review. (Chairman: J. Cumberlege) HMSO, London
DEPT. of HEALTH & SOC. SECURITY	1986b	Primary Health Care - An agenda for discussion HMSO, London
DEPT. of HEALTH	1989	Working for Patients White Paper on review of the National Health Service HMSO, London
DEPT. of HEALTH	1989	Strategies for Nursing HMSO, London
DEPT. of HEALTH	1990	National Health Service and Community Care Bill HMSO, London
DICKOFF, J., JAMES P. & WEIDENBACK, E.	1968	Theory in a Practice Discipline Nursing Research,17,5,415-435
DICLEMENTE, C.C.	1981	Self-efficacy and smoking cessation maintenance: a preliminary report Cog. Ther. Research 5, 175-187 Cited by O'Leary 1985 (Op. cit.)

DICLEMENTE, C.C.	1986	Self-efficacy and the addictive behaviours J. of Social & Clinical Psychology 4, 302-315
DIMATHEW, M.R. & HAYS, R.	1980	The Significance of patients perceptions of physician conduct: a study of patient satisfaction in a family practice centre. J. of Community Health, 6, 18-34
DINGWALL, R.	1977	Collectivism, Regionalism and Feminism: Health Visiting and British Social Policy 1850-1975 J. of Soc. Policy 6, 3, 291-313
DOBBY, J. & BARNES, A.	1987	Measuring the Need for, and value of, routine Health Visiting: Part 1 Health Visitor 60, 3, pp 81-82
DOBBY J. & BARNES A.	1987	Measuring the need for and Value of Routine Health Visting: Part 2 Health Visitor 60, 4, pp 114-115
DONABEDIAN, A.	1968	Promoting Quality through evaluating the process of patient care Medical Care 6, 3, 181-202
DONNELLY, G.	1987	The Promise of Nursing Process: An evaluation Holistic Nurse Practictioner 1, 3, 1-6
D'ONOFRIO, C.N.	1980	Patient compliance and Patient education - some fundamental issues. In: Squyres, W. (Ed) Patient Education Springer, New York
DRENNAN, V.	1985	Working in a Different Way N. Paddington District Health Authority
DUNNELL, K. & DOBBS, J.	1980	Nurses working in the Community HMSO, London
DURYEA, E.J.	1983	Decision making and Health Education J. of School Health, 53, 1, 29-32
DWORKIN P. et al	1990	Maternal Perceptions of Child Health Care Health Visitor, 63,10,339-341
EDSALL PROFESSIONAL SERVICES	1985	Evaluation Report of the Health Visiting Process Conference, Central Hall, Westminster 1st November Edsall & Co. Ltd., London

EISENTHAL, S.; KOOPMAN, C. & LAZARE, A. 1983
Process Analysis of two dimensions of the Negotiated Approach in Relation to Satisfaction in the Initial Interview
J. of Nervous and Mental Disease, Vol. 171, 1, 49-54

EISENTHAL, S. & LAZARE, A. 1976
Evaluation of the Initial Interview in a walk-in Clinic
J. of Nervous and Mental Disease, Vol. 162, 3, 169-176

EMERY, J. 1976
Unexpected death in infancy. Early recognition of the 'at risk' situation
In: Recent Advances in Paediatrics
Ed. David Hull
Churchill Livingstone : Edinburgh, pp 203-220

EMERY, J. 1987
The Ethics of Intervention in Child Abuse and Sudden Infant Death
Health Visitor 60, 10, 332-334

FAHRENFORT, M. 1987
Patient Emancipation by health Education: An impossible goal?
Pt. Education and Counselling 10, 25-37

FATCHETT A.B. 1990
Health Visiting: A Withering Profession?
J. of Adv. Nursing 15, 216-222

FIELD, P.A. 1983
An ethnography: four public health nurses' perspectives of nursing
J. of Adv. Nursing 8, 3-12

FIELD, P.A. 1987
The Impact of Nursing Theory on the Clinical Decision Making Process
J. of Ad. Nursing 12, 563-371

FIELD, P.A. & MORSE, J.A. 1985
Nursing Research - the application of qualitative approaches
Croom Helm, London

FIELD, S.; DRAPER, J.; KERR, M. & HARE, M. 1982
A Consumer view of the Health Visiting Service
Health Visitor 55, 6, 299-301

FILSTEAD, W.J. (Editor) 1971
Qualitative Methodology
Markham Pub. Co., Chicago, Illinois, USA

FITZPATRICK, R. & HOPKINS, A. 1983
Problems in the Conceptual Framework of Patient Satisfaction Research : an empirical explanation
Soc. of Health and Illness 3, pp297-311

FOSTER, M.C. 1988
The French Pericultrice
Health Visiting Theory and Practice: Meeting held 17 March
Thomas Coram Research Unit, London

FOSTER M.C. & MAYALL B.	1990	Health Visitors as Educators J. of Adv. Nursing 15, 286-292
FOXMAN, R.; MOSS, P.; BOLARD, G. & OWEN, C.	1982	A consumer view of the Health Visitor at six weeks post-partum Health Visitor 55, 6, 302-305, 308
FREEMAN, S.	1987	Health promotion talk in family practice encounters Soc. Sci & Med. 25, 8, pp 961-966
FRIERE, P.	1972	Pedagogy of the Oppressed Penguin, Harmondsworth
FRIEDSON, E.	1970	The Profession of medicine Dodd-Mead, N.Y.
GARFINKEL, H.	1967	Studies in Ethnomethodology Englewood Cliffs, New Jersey
GEORGE, J.B. (Chair)	1980	Nursing Theories Report Prentice Hall Englewood Cliffs, New Jersey
GLASER, B.G. & STRAUSS, A.L.	1965	Temporal Aspects of dying as a non-scheduled status passage Am. J. of Sociology 71, 43-59
GLASER, B.G. & STRAUSS, A.L.	1967	The Discovery of Grounded Theory Excerpt from The Discovery of Grounded Theory: Strategies for Qualitative research, Blaine Press, pp. 1-35
GOLDSTONE, L. A. & BALL, J.A.	1984	The quality of nursing services Nursing Times, 29 August, pp 56-58
GOODWIN, S.	1983	Open Secrets Nursing Mirror, 29 June, pp22
GOODWIN, S.	1988	Whither Health Visiting? Keynote Speech at Health Visitor's Association Annual Study Conference, Bournemouth,Health Visitor's Association, London
GRAHAM, H.	1979	Women's Attitudes to the Child Health Services Health Visitor, Vol. 52, pp 175-178
GRAHAM, H.	1985	Health and Welfare MacMillan Education, Basingstoke

GREEN, L.W.	1976	The Potential of Health Education includes Cost-Effectiveness Hospitals, JAHA,50,57-61 Cited by Roter, D. 1977 Op.cit.
GREENFIELD, S.; KAPLAN, S.; & WARE, J.	1985	Expanding Patient Involvement in Care Annals of Intern. Med. 102, 520-528
HALL, D.	1989	Health for all Children Oxford University Press, Oxford.
HARGIE, O., SAUNDERS, C. & DICKSON, D.	1981	Social Skills in Interpersonal Communication. Croom Helm, Beckenham
HAUGH & LAVIN	1979	Public challenge of physician authority. Med. Care, 17, 844-858
HAYWARD, J.	1975	Information: A Prescription against Pain RCN, London
HEALTH VISITOR'S ASSOCIATION	1985	Health Visiting and School Nursing - the Future. HVA, London.
HEALTH VISITOR'S ASSOCIATION	1988	Bridging the Gap HVA, London
HEDLEY, C.; GRIEVE, L. et al		1982 Using the need/problem oriented method of record-keeping Health Visitor 55, 5, pp 211-215
HENDERSON, V.	1987	Nursing Process - a critique Holistic Nurse Practitioner 1, 3, 7-18
HENDY, A.	1983	The Nursing Process and Health Visiting Health Visitor Vol. 56, 6, pp 197-200
HENNESSEY, D.	1986	Health Visiting and Mothers Unpublished Ph.D. Thesis, Southampton University
HERITAGE, J.	1984	Garfinkel and Ethnomethodology Polity Press, Cambridge
HINDS, P., SCANDRETT-HIBDEN, S. & McAULAY, L.	1990	Further Assessment of a Method to Estimate Reliability and Validiity of Qualitative Research Findings. J. of Ad. Nursing, 15, 430-435

HOCKEY, L.	1978	Research Methodology and the Process of Nursing Unpub. paper presented to Royal College of Nursing Research Society Annual Conference.
HOLMES, P.	1985	Does the Process help the Patient? Nursing Times, 23 January, p 20
HORSLEY, E.D.	1987	Growing Old, not unhealthy Health Visitor, 60, 8, 258-259
HULL ,W.	1989	Measuring Effectiveness in Health Visiting Health Visitor, 62,4,113-115
HUNT, M.	1982	Caseload Profiles: Their implications for Evaluating Health Visiting Practice Health Visitor 55, 12, pp 662-665
HURST, K.	1983	The quiet revolution Nursing Mirror, 26 Oct., 36-40
ILLICH, I.	1976	Limits to Medicine Penguin, Harmondsworth
IVEY, I.	1971	Microcounselling: Innovations in Interviewing Training. C.C. Thomas, Illinois
JEFFEREYS, M.	1965	An anatomy of social welfare services Joseph
JICKS, T.D.	1979	Mixing qualitative and quantitative methods: Triangulation in Action Administrative Science Quarterly, 24, 602-611
JOHNSON, W.L. & HARDIN, C.A.	1962	Content and Dynamics of home visits of public health nurses. Part I. American Nurses Foundation Inc., N.Y.
JOHNSON W.L.	1969	Content and Dynamics of home visits of public health nurses. Part 2. American Nurses Foundation Inc., N.Y.
JUNKER, B.H.	1960	Field Work: An introduction to the Social Sciences University of Chicago Press, Chicago
KATON, N. & KLEINMAN, A.	1980	Doctor-Patient Negotiation and other social science strategies in patient care In: Eisenberg, L. & Kleinman, A. (Eds) The Relevance of Social Service for Medicine, pp 253-279 D. Reidel Publishing, N.Y.
KENDALL, S.	1991	A home visit by a health visitor using Bandura's theory of self-efficacy. In: White A. (Ed.) Caring for Children - towards partnership with families. Edward Arnold, Sevenoaks.

KIM, H.S.	1981	Patients attitudes regarding collaborative decision making in nursing Unpublished paper. University of Rhode Island
KIM, H.S.	1983	Collaborative Decision making in Nursing Practice: A theoretical framework In: Advances in Nursing Theory Development
KIM, H.S.	1985	Nurses attitudes in Collaborative decision making. Unpublished paper. University of Rhode Island
KING, J.	1983	Patients Health Beliefs In: Pendleton, D. & Hasler, J. (Eds) Doctor Patient Communication Academic Press, London
KING, J.	1987	Women's Attitudes towards Cervical Smear Update, 34, 2, 25-27
KLEINMAN, A.; EISENBERG, L. & GOOD, B.		1978 Culture, Illness and Care. Annals of Int. Med. 88 : 251-258
KRATZ, C.	1975	Participant Observation in dyadic and triadic situations. Int. J. of Nursing Studies, 12, pp 169-174
KRANTZ, O.; BAUM, A. & WIDEMAN, M.	1980	Assessment of Preferences for self-treatment and information in health care J. of Personality and Social psych. 39, 5, 977-990
LANGTON, B.M.	1963	Early Health Visiting Nursing Times Vol.59, pp 1247-8
LAURI, S.	1987	The Public Health Nurse as a guide in infant care and education J. of Advanced Nursing 6, pp 297-303
LEININGER, M.M. (Ed)	1985	Qualitative Research Methods in Nursing Grune and Stratton, Orlando, Florida, USA
LEWIS, F.M.; MORISKY, D.E. & FLYN, B.S.	1978	A test of construct validity and health locus of control: effects on self reported compliance for hypertensive patients. Health Ed. Monographs 6, 138-148
LEY, P.	1972	Comprehension, Memory and the Success of Communications with the Patient. J. of Inst. of Health Ed., 10,23-29
KRATZ C.	1979	The Nursing Process Ballière Tindall, London

LEY, P.	1976	Towards better doctor-patient communications. In: Communications between Doctors and Patients (Bennett A. Ed.) O.U.P. for Nuffield Provincial Hospitals Trust, London.
LEY, P. & SPELMAN, M.S.	1967	Communicating with the Patient. Staples Press, London
LITTLEFIELD, V. & ADAMS, B.	1987	Patient participation in alternative prenatal care: Impact on satisfaction and health locus of control. Research in Nursing & Health, 10,139-148
LOWE, M.	1987	The Health Visiting Process is not enough: bring in the auditors. Health Visitor, 60, 1, 17
LUKE J. & JOYCE S.	1986	A Pilot Study on Appointment Visiting Health Visitor, 59, 8, 249-250
LUKER, K.	1978	Goal attainment: A possible model for assessing the role of the health visitor. Nursing Times (Occ. Papers) 74, 1257-1259
LUKER, K.	1982	Evaluating Health Visiting Practice Royal College of Nursing, London
LUKER, K.	1985	Evaluating Health Visiting Practice In: Luker, K. & Orr, J. (Eds) Health Visiting Blackwell Scientific, Oxford
LUKER K. & CHALMERS K.	1989	The referral process in health visiting Int. J. of Nursing Studies 26,2, 173-185
LUKER K. & CHALMERS K.	1990	Gaining access to clients: the case of health visiting. J. of Adv. Nursing 15, 74-82
LYTHGOE, E.	1983	Teaching Health Visitor Students to Communicate Health Visitor, 56, 368-369
MACLEOD CLARK, J.	1982	Nurse-Patient verbal interactions: A study of conversations on selected surgical wards Unpub. PhD Thesis, University of London
MACLEOD CLARK, J.; HAVERTY, S. & KENDALL, S.	1987	Helping people to stop smoking - assessing the efficiency of the nurses' role. Research Report No. 19 Health Education Authority, London

MACLEOD CLARK, J., HAVERTY S. & KENDALL, S. 1990 Helping People to Stop Smoking: a Study of the Nurses' Role. J. of Ad. Nursing, 16, 357-363

MACQUEEN, I.A.G. 1962 From carbolic powder to social counsel Nursing Times 58, 866-868 Cited by Clark, J. 1973, p 14

MALLET, J. 1987 Unpub. paper presented at Kings College, London

MARRIS, T. 1969 The Work of Health Visitors in London Greater London Council Report of Planning and Transportation Research Report No. 12, 1971

MARSDEN, M. 1985 Implementing the Health Visiting Process Health Visitor, 58, 6, 166-169

MASLOW, A. 1969 A Theory of Metamotivation: the biological rooting of the value of life. In: Readings in Humanistic Psychology (Sutich A. and Vich M. Eds.) Theatre Press, New York

MAUKSCH, I.G. & DAVID, M. 1972 Prescription for Survival American J. of Nursing, 12, 2189-93

MAYALL, B. 1988 The Division of Labour in Child Care - Mothers and Others Health Visiting - Theory and Practice Meeting held on 17th March 1988 Thomas Coram Research Unit, London

MAYALL, B. & GROSSMITH, C. 1985 The Health Visitor and the Provision of Services Health Visitor, 58, 12, 349-352

MAYALL, B. & FOSTER, M.C. 1988 Parents and Health Visitors: Perspectives on preventive health care Thomas Coram Research Unit London

McCARTHY, M.M. 1981 The Nursing Process: application of current thinking in clinical problem solving J. of Advanced Nursing, 6, 173-177

McFARLANE OF LLANDUFF 1982 Responsibility for the Future Development of Health Visiting Health Visitor, 55, 6, 273-277

McINTOSH, J. 1986 A Consumer Perspective on the Health Visiting Service
Social and Paediatric Research Unit
University of Glasgow

McINTOSH, J. 1987 Interpersonal Style and Professional Effectiveness
Focus, No. 7, pp 6-8

McINTYRE, K.O.; LICHENSTEIN, E. & MERMELSTEIN, R.J. 1983 Self-efficacy and relapse in smoking cessation: a replication and extension
J. Consult. Clin. Psychol. 51, 632-633

McKAY, A.; HODGSON, R. & SANDERS, A. 1987 The Birth of the Health Visiting Process
Midwife, Health Visitor and Community Nurse

McKEWAN, J. 1983 Participation in Health
Croom Helm, London

McWEENEY, P. & EMERY, J. 1975 Unexpected post-natal deaths (cot deaths) due to recognisable disease.
Archives of Disease in Childhood
Vol. 50, pp 191 -

MELIA, K. 1982 "Tell it as it is" - qualitative methodology and nursing research: understanding the student nurses' world.
J. of Adv. Nursing, 7, 327-335

MENZIES, J. & HARRISON, F. 1985 The Nursing Process for Health Visitors.
Health Visitor, 58, 6, 165-166

MILES, M. & HUBERMAN, A.M. 1984 Qualitative Data Analysis
Sage Publications, London

MILLER, A. 1985 Does the Process help the Patient?
Nursing Times, 26 June, pp 24-27

MINISTRY OF HEALTH, DEPT. OF HEALTH FOR SCOTLAND, AND MINISTRY OF EDUCATION 1956 Working Party on the Field of Work, Training and Recruitment of Health Visitors. (Jameson Report)
HMSO, London

MINISTRY OF HEALTH AND DEPT. OF HEALTH FOR SCOTLAND 1959 Working Party on Social Workers in the Local Authority Health and Welfare Services
HMSO, London

MITCHELL, J. CLYDE 1983 Case and situation analysis
Sociological Review, May, 187-211

MONTGOMERY-ROBINSON, K. 1986 Accounts of Health Visiting
In: While A. (Ed.) Research in Preventive Community Care

MONTGOMERY-ROBINSON, K.	1987	The Social Construction of Health Visiting Unpub. PhD Thesis, Polytechnic of the South Bank
MOSS, P.; BOLLARD, G.; FOXMAN, R. & OWEN, C.	1986	The First Six Months after Birth: Mother's views and Health Visitors Health Visitor 59, 3, pp 71-74
MUNTZ, A.C.	1988	Value Judgements in Health Visiting Health Visitor 61, 5, 145-146
NEUMANN, B.M. & YOUNG, R.J.	1972	A model for teaching total person approach to patient problems Nursing Research 1, 3, pp 264-269
NIGHTINGALE, F.	1891	Letter to Mr Fredrick Verney on the teaching of health at home. In: Buckinghamshire County Council (1911)
NIGHTINGALE, F.	1893	Sick Nursing and Health Nursing. A paper read at the Chicago Exhibition 1893 In: Seymer L.R. (Ed.) 1954 Selected writings of Florence Nightingale, N.Y. Macmillan p. 353-376. Cited by Clark, J. 1973, (Op. cit)p 11
O'LEARY, A.	1985	Self-Efficacy and Health Behav. Res. Ther. 23, 4, pp 437-451
OREM, D.	1985	Nursing: Concepts of Practice McGraw Hill, New York
ORLANDO, I.J.	1961	The Dynamic Nurse-Patient Relationship. Portnam, New York
ORR, J.	1978	Consumer Perceptions of Health Visiting Unpub. MSc Thesis, University of Manchester
ORR, J.	1980	Focus on Health Visiting Royal College of Nursing, London
ORR, J.	1983	Is Health Visiting Meeting Today's Needs? Health Visitor, 56, 6, 200-203
ORR, J. & LUKER, K. (Eds)	1985	Health Visiting Blackwell Scientific Pub., Oxford
PARSONS, T.	1951	The Social System Free Press, New York
PATTIE, A.H. & GILLEARD, C.J. (Eds)	1979	CAPE Scales - Manual of the Clifton Assessment Procedures for the Elderly Hodder & Stoughton, Chigwell, Essex

PENDLETON, D. & HASLER, J. 1983 Doctor-Patient Communication Academic Press, London

PENDELTON, L. & HOUSE, W.C. 1984 Preferences for Treatment Approaches in Medical Care: College Students versus Diabetic Outpatients Medical Care,22,7,644-646

PERKINS, E. 1982 Decision-making: The Whooping Cough Dilemma Nottingham Practical Papers in Health Education No. 8

PERKINS, E. 1983 Decision-making: Breast or bottle feeding? Nottingham Practical Papers in Health Education No. 9

PHANEUF, M.C. WANDELT, M.A. 1981 Obstacles to and Potentials for Nursing Quality Appraisal Quality Review Bulletin, 4

POLIT, D. & HUNGLER, B. 1987 Nursing Research - Principles and Methods Lippincott Company, Philadelphia

POWELL,J. 1986 Study of home visiting of babies in Gosport at high risk of sudden infant death In: While A. (ed.)Research in Preventive Community Nursing Care. Wiley : Chichester

PRENTICE-DUNN, S. & ROGERS, R. 1986 Protection Motivation Theory and Preventive Health : Beyond the Health Belief Model Health Education Research,1,3,153-161

PRICE, B. 1984 A framework for Patient Education Nursing Times, 8 August, pp 28-30

PROTESTOS, C.D. 1973 Obstetric and Perinatal Histories of Children who died Unexpectedly (cot death) Archives of Disease in Childhood Vol. 48, pp 835-841

PUBLIC HEALTH ALLIANCE 1988 Beyond Acheson: An Agenda for the New Public Health Public Health Alliance, Birmingham

REPORT OF THE INTER-DEPARTMENTAL COMMITTEE 1904 Quote from p. 54 Cited by Dingwall 1977, (Op. Cit.) p. 295

REPORT OF THE INTER-DEPARTMENTAL COMMITTEE ON PHYSICAL DETEREORATION 1904 Cmnd. 2175 HMSO Summary of Evidence, para 254 Cited by Robinson, J. 1982, (Op. cit) p. 7

REYNOLDS M. & HAY H.	1986	Health Visiting by Appointment Health Visitor, 59,8,252-254
RHODES, B.	1984	An Investigation into the usefulness of a theoretical decision making model of nursing. Unpub. PhD Thesis, Dept. Sociology, Leeds University
RHODES, B.	1985	Occupational ideology and clinical decision making in British nursing Int. J. of Nursing Studies, Vol. 22, No. 3, pp 241-257
RICHARDS, D. & LAMBERT, P.	1987	The Nursing Process: the effects on patients satisfaction with nursing care. J. of Ad. Nursing 12, 559-562
ROBERTSON, M. & BOYLE, J.	1984	Ethnography: Contributions to nursing research J. of Ad. Nursing 9, 43-49
ROBINSON, J.	1982	An Evaluation of Health Visiting Council for Education and Training of Health Visitors, London.
ROBINSON, J.	1982	The Health Visitor - an authority on child rearing or an agent of social control? Health Visitor 55, 3 March, pp 113-116
ROBINSON, J.	1983	The Role Dilemma of Health Visiting Health Visitor 56, 1 Jan, pp 22-24
ROGERS, J.	1982	Introducing the Health Visiting Process Health Visitor, Vol. 55, 55, pp 204-209
ROPER, N; LOGAN, W. & TIERNY, A.	1985	The Elements of Nursing Churchill Livingstone, Edinburgh
ROSS, F.	1988	Information sharing for patients, nurses and doctors: Evaluation of a drug guide for old people in Primary Health Care. In: Johnson R. (ed.) Recent Advances in Nursing:(21) Excellence in Nursing Churchill Livingstone, Edinburgh
ROTER, D.	1977	Patient Participation in the Patient-Provider Interaction - the effect of patient questions asking on the quality of interaction, satisfaction and compliance. Health Ed. Monograph, Winter, Vol. 5, No. 4, pp 281-315

ROTTER, J.B.	1966	Generalized expectancies for internal versus external control of reinforcement. Psychgol. Monog. 89, 1 (Whole No. 409)
ROYAL COLLEGE OF NURSING	1977	Ethics Related to Research in Nursing Royal College of Nursing, London
ROYAL COLLEGE OF NURSING	1981	Towards Standards Working Committee on Standards of Nursing Care (England and Wales) Royal College of Nursing, London
ROYAL COLLEGE OF NURSING	1983	Thinking about Health Visiting Royal College of Nursing, London
ROYAL COLLEGE OF NURSING	1986	Commission of the Royal College of Nursing (Chairman: Sir H. Judge) Royal College of Nursing, London
ROYAL COLLEGE OF NURSING	1988	Report of the Commission on the NHS and Health Care in the U.K. (Chairman: Rabbi Julia Neuberger) Royal College of Nursing, London
RUSSELL, M., WILSON, C., TAYLOR, M. & BAKER C.	1979	The Effect of General Practitioners Advice Against Smoking. Br. Medical Journal, 291, 1240-1244
SACKS, H.; SCHEGLOFF, & JEFFERSON, G.	1974	Simplest Systematics for the organisation of turn-taking for conversation. Language, 50, 696-735
SCHAEFER, J.	1974	The Interelationships of Decision Making and the Nursing Process Am. J. of Nursing, Vol. 74, No. 10,1852-1856
SCHEGLOFF E. & SACKS H.	1973	Opening up Closings. In:Turner R. (1974) Ethnomethodology. Penguin, Harmondsworth
SCHON, D.	1983	The Reflective Practitioner: How Professionals think in Action. Basic Books, New York.
SCHROCK, R.	1982	Is Health Visiting a Profession? Health Visitor, 55, 3, 104-107

SCHULMAN, B.	1979	Active Patient Orientations and Outcomes in Hypertensive Treatment Medical Care, 17,267-280
SEFI, S.	1985	The First Visit: A study of Health Visitor/Mother verbal interaction. Unpub. M.A. Dissertation, University of Warwick
SEFI S.	1988	Health Visitors talking to mothers. Health Visitor 61, 7-10
SEEDHOUSE D.	1986	Health - The foundations for achievement John Wiley and Sons, Chichester
SEYMER, L.R.(ed.)	1954	Selected writings of Florence Nightingale MacMillan, N.Y.
SLACK, W.	1977	The Patient's right to decide Lancet, 30 July
SLIMMER, L. & BROWN, R.	1985	Parent's Decision-making process in Medication Administration for control of Hyperactivity J. of School Health, Aug, 55, 6, 221-225
SIMMEL, G.	1964	The Sociology of Georg Simmel Translated and edited by K.H. Wolff The Free Press of Glencoe Cited by Kratz, C. 1975 (Op. cit)
SHERER, M., MADDOX, J., MERCANDANTE, B., PRENTICE-DUNN, S., JACOBS, B. & ROGERS, R.W.	1982	The Self-efficacy scale: construction and validation Psychological Reports, 51, 663-671
SHILLINGER, F.L.	1983	Locus of Control: Implications for Nursing Practice Image: The J. of Nursing Scholarship 15, 2, 58-63
SMITH, R. et al	1984	Measuring Desire for Control of Health Care Processes J. of Personality and Soc. Psychology, 47, 3,415-426
SMITH, A. & JACOBSON, B. (Eds.)	1988	The Nation's Health Kings Fund, London
SOHIER, R.	1988	Multiple Triangulation and Contemporary Nursing Research Western J. of Nursing Research 10, 6,732-742

SPEEDLING, E.J. & ROSE, D.	1985	Building an effective doctor-patient relationship: From patient satisfaction to patient participation Soc. Sci. Med. 21, 2, pp 115-120
SPSS Inc.	1983	Statistical Package for the Social Sciences (SPSSX) McGraw Hill, New York
STEELE, D. et al	1987	The Activated Patient: Dogma, Dream or Desdiratum?Beyond Advocacy: A review of the activated patient concept. Pt. Ed. & Counselling 10, 3-23
STERN, P. & MOXLEY, L.	1984	Qualitative Research: The nurse as grounded theorist. Health Care for Women International 5,371-385
STEWART, M.	1984	What is a Successful Doctor-Patient Interview? A Study of Interactions and Outcomes. Soc. Science and Medicine,19,2,167-175
STONE, G.	1979	Patient Compliance and the role of the expert. J. of Social Issues, 35, 1, 34-59
STRULL, W.M., BERNARD, L. & CHARLES, G.	1984	Do patients want to participate in medical decision making? J. Am. Med. Ass., 252, 21, pp 2990-2994
SUCHMAN, E.A.	1967	Evaluation Research Russell Sage Foundation, N.Y.
SZASZ, T.S. & HOLLENDER, M.H.	1956	A Contribution to the Philosophy ofMedicine: the basic models of the doctor patient relationship. Arch. of Int. Med., 97, 585-592
THAYER, R.	1973	Measuring Need in the Social Services Soc. and Economic Admin., 7 May, 91-105
THOMAS CORAM RESEARCH UNIT	1988	Health Visiting - Theory and Practice A Day Conference held on Thursday,17 March, 1988
THOMSON, A.	1988	Unpublished paper given at the Nursing Times Primary Health Care Conference, November 1988
THOMPSON, E.P.	1965	The making of the English working Class Victor Gollanz Ltd., p. 407 Cited by Robinson, J. 1982 (Op. cit.)

TILLEY, J.D.	1987	The nurses' role in patient education: incongruent perceptions among nurses and patients. J. of Ad. Nursing, 12, 291-301
TONES, K.	1987	Devising Strategies for Preventing Drug Misuse: the role of the Health Action Model. Health Education Research,2,4,305-317
TOWNSEND, P.(Ed.)	1970	The Fifth Social Service - a Critical Analysis of the Seebohm Proposals Fabian Society, London. Cited by Robinson, J. 1982 Op. cit.
TOWNSEND, P.	1982	The Policy Implications of a Positive Approach to Health Health Visitor, 55, 3, 97-101
TRANDEL-KARENCHUK, D.M.	1982	Patient Participation in Decision Making Nurse Practitioner 7, 5, 46-52
TREVELYAN, G.M.	1946	English Social History 2nd ed. Longmans Cited by Clark, J. 1973 (op. cit.)
TROW, M.	1971	Comment on "Participant Observation and Interviewing: a comparison" In: Filstead, W.J. (ed) Qualitative Methodology Markham Pub. Co., Chicago
TUCKETT, D.; WILLIAMS, A.; BOULTON M. & OLSON, C.	1982	Final Report on the Patient Project Health Education Studies Unit, Health Education Council, London
TUCKETT, D.; OLSON, C.; WILLIAMS, A. &, BOULTON M.	1982	The Patient Project Health Education Studies Unit, Health Education Council, London
TUCKETT, D., BOULTON M., OLSON C. & WILLIAMS A.	1985	Meetings Between Experts Tavistock Publications, London
UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES & HEALTH VISITORS	1984	Code of Professional Conduct U.K.C.C., LOndon
UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES & HEALTH VISITORS	1986	Project 2000 U.K.C.C., London

VALANIS, B.G. & RUMPLER, C.H.	1985	Helping Women to choose breast cancer treatment alternatives. Cancer Nursing, June, 8, 3, 167-175
VERTINSKY, I.; THOMPSON, W. & UYENO, D.	1974	Measuring Consumer Desire for Participation in Clinical Decision Making. Health Sciences Research, Summer, 9,121-134
VON BERTALAFFNY, L.	1968	General Systems Theory: Foundations, development applications Bragiller, New York
WALLSTON, B. & WALLSTON, K.	1978	Locus of Control and Health: A review of the literature. Health Education Monograph 6, 2,107-117
WALLSTON, K.; WALLSTON B. & DEVELLIS, R.	1978	Development of the Multidimensional Health locus of Control Scales (MHLC) Health Education Monograph 6, 2,160-170
WALLSTON, B.; WALLSTON K, FORSBERG, P. & KING, J.	1984	Measuring Desire for Control of Health Care Processes. J. of Personality & Soc. Psych, 47, 2,415-426
WALTON, I.	1986	The Nursing Process in Perspective: A literature review. Dept. of Social Policy and Social Work University of York
WARD, M.	1988	Sociolinguistics and the Nursing Process Senior Nurse, 8, 11, 21-23
WANDELT, M.A. & AGER, J.W.	1964	Quality of Patient Care Scale Appleton Century Crofts, New York
WARE, J.E. & SYNDER, M.K.	1975	Dimensions of patient attitudes regarding doctors and medical care services. Med. Care, 13, 669-682
WARNER, U.	1984	Asking the Right Questions Nursing Times, Community Outlook, 13 June, 214-216
WARNER, U	1984	Achieving Goals Nursing Times, Community Outlook, 11 July, 242-244
WARNER, J. & FORRYAN B.	1988	Therapeutic Aspects of Health Visiting Health Visitor, 61,2,39-40

WATERWORTH S. & LUKER K.	1990	Reluctant Collaborators: do patients want to be involved in decisions concerning care? J. of Adv. Nursing 15, 971-976
WATSON, P.J.	1975	A Time Study of Health Visitors Work Unpub. Report Scottish Home & Health Dept. (MSRC (77) 1/9/1)
WATSON, P.J.	1976	Studying Work Nursing Times (Occasional Paper) 1979 75, 20, 81-84
WATSON E.	1986	A Mismatch of Goals? Health Visitor 59, 75-77
WATSON E. & SIM J.	1989	The Health Visitor's Visit Health Visitor, Vol.62,7, 214 -217
WEATHERLY D.	1988	A Survey of Client's Views in one Health Visitors Case Load Health Visitor, 61, 137-138
WEIR, M.	1991	Towards an holistic understanding of health and illness. Health Visitor, 64,3,77-79
WEITZEL, M.	1989	A test of the health promotion model with blue collar workers. Nursing Research 38, 2, 99-104
WEST M.	1989	Innovation in Health Visiting Health Visitor, 62,2,46-48
WHILE, A.	1985	Health Visiting and Health Experiences of Infants in three Areas. Unpub. PhD Thesis, University of London
WHILE, A.	1989	The needs of dying children and their families. Health Visitor 62, 6, 176-178
WHITEHEAD, M.	1988	The Health Divide Penguin, London
WILLER, B. & MILLER, G.	1976	Client Involvement in goal setting and its relationship to therapeutic outcome J. of Clinical Psychology, July, Vol. 32, No. 3, 687-690
WILSON BARNETT, J.	1978	Stress In Hospital RCN, London
WILSON, M. & COWAN, J.	1982	Putting the Health Visiting Process into Practice Health Visitor, 55, 5, pp 209-211

WISEMAN, J.	1982	Health Visiting: What will be its function in the future? Nursing Times, Occ. Papers,78, 13,49-52
WISEMAN J.	1982	What Health Visitors Do. Nursing Times, Occ. Papers,78,29,113-116
WORLD HEALTH ORGANISATION	1948	Constitution W.H.O, Geneva
WORLD HEALTH ORGANISATION	1978	Alma Ata 1978: Primary Health Care W.H.O., Geneva
ZOLA, I.	1972	Medicine as an Institution of Social Control Sociological Review 20, 4, 487-509

Appendix 1

King's College London (KQC)

UNIVERSITY OF LONDON

CHELSEA CAMPUS

552 KING'S ROAD,LONDON SW10 0UA TELEPHONE:01-351 2488

DEPARTMENT OF NURSING STUDIES HEAD OF DEPARTMENT
Professor Jenifer Wilson-Barnett, PhD,SRN,FRCN

Client Consent Form Code:

Outline of the Project

Dear Parent,

I am a qualified nurse and a health visitor. I am working in the Department of Nursing Studies at Kings College, London University. In order that we can understand more about health visiting and how to improve the services given to families I am carrying out a research project to find out what actually happens when the health visitor calls to see you.

In order to do this I need to be able to observe directly what happens between a parent and the health visitor and to study the conversation in detail I would like to tape record it. I would also like to look at how you both viewed the visit and to do this I would like to interview you immediately following the visit. All information collected will be strictly confidential and if at any stage you decide to withdraw from the study you will be free to do so without affecting your rights within the health service. I would be very grateful if you would agree to take part in the study.

Thanking you for your help,

Sally Kendall, B.Sc. (Hons.), RGN, RHV

I, of,
have read the above outline of the project and have had my involvement in the study fully explained to me and understand what this entails. I agree to take part in the study on the understanding that all information is confidential and that I am free to withdraw from the study at any time should I wish to do so.

Signed:

Date:

Appendix 2

King's College London (KQC)

UNIVERSITY OF LONDON

CHELSEA CAMPUS

552 KING'S ROAD,LONDON SW10 0UA TELEPHONE:01-351 2488

DEPARTMENT OF NURSING STUDIES HEAD OF DEPARTMENT
Professor Jenifer Wilson-Barnett, PhD, SRN, FRCN

HEALTH VISITOR CONSENT FORM CODE:

OUTLINE OF PROJECT

Dear Health Visitor

I am undertaking some research in the Department of Nursing Studies, Kings College, London University. Whilst research in health visiting at the moment is limited, we do need to increase our knowledge about the nature of health visiting and our clients' needs. This study will be investigating and describing the health visitor/client interaction and attempting to explain some aspects of health visiting. In order to do this I will be observing what actually happens during a visit and tape recording the interaction for in-depth analysis. I would also like to interview both the health visitor and client concerned in order to look at their perceptions of the visit. I would be very grateful if you would agree to take part in the study by allowing me to accompany you on a number of home visitsto be agreed between us. All data collected will be strictly confidential. If, for any reason, you decide to withdraw from the study you will be free to do so.

Thanking you very much for your help,

Sally Kendall B.Sc.(Hons.), RGN, RHV.

I, of

have read the above outline of the study and have had my involvement in the study fully explained to me and understand what this entails. I agree to take part in the study on the understanding that all information is confidentail and that I may withdraw from the study at any stage should I wish to do so.

Signed:

Date:

Appendix 3

HEALTH VISITOR QUESTIONNAIRE (HVQ)

1. Code: 2. Date:

3. What were your objectives for this visit?

4. What needs or problems have you identified as a result of this visit?

5. Have you left your client with any plans for action/change?

Yes No

6. If yes, what are her plans?

7. How will you evaluate this visit?

8. What are your plans for future visits/contacts?

Appendix 4

CLIENT QUESTIONNAIRE (CQ)

1. Code: 2. Date: 3. Age:

4.Ages of children 5a Fathers Occupation

5b.Mother's occupation 6. Marital status

7. Do you normally know in advance when your health visitor is coming?

8. Why do you think the health visitor came to see you today?

9. What were you expecting from the visit?

10. What are your main health needs at the moment?

11. Were there any problems which you did not have a chance to discuss today?

12. Following today's visit, have you any plans for action or change, either now or in the future?

13. What arrangements did you make with the health visitor to meet again?

14. What is your understanding of the health visitor's role?

Appendix 5

HEALTH VISITOR INTERVIEW (HVI)

1. Code: 2. Age: 3.Sex: M/F

4. Qualifications:
RGN
RHV
SCM
FWT
RHVT
Degree (Nursing)
Degree (Other, specify)
Other qualifications

5.Year qualified as RHV:

6. How long have you been working in this Health Authority?

7a. Are you G.P. Attached? Yes No

b. Geographical? Yes No

8.Where is your base?:
Health Centre
Health Authority Clinic
G.P. Surgery
Other (specify)

9. What is the approximate size of your caseload in terms of:
a. Number of families
b. Number of children under five
c. Number of handicapped children (all ages)
d. Number of children "at risk"
e. Number of elderly

10a. How many "fixed sessions" do you have per week

10b. What are your "fixed sessions"?

11. What are your commitments outside "normal" health visiting? (e.g. hospital liason)

12. It has been suggested that health visitors should "enable" their clients. What do you understand by this term?

13. What do you feel about client participation in their health care?

14. Has the Health Visiting Process been implemented in your area?

Yes No

15a. If yes, what training were you given prior to implementation?

15b. How has implementation the HVP affected your practice?

16. What does the term Health Visiting Process mean to you?

17. What do you think the main advantages of the HVP are for the Health Visitor?

18. What do you think are the main disadvantages of the HVP for the Health Visitor?

19. What , in your opinion, are the advantages of the HVP for the client?

20. What do you think are the possible disadvantages of the HVP for the client?

21. Any other comments